

SERFF Tracking #: CUNA-128479621

State Tracking #:

Company Tracking #: A10A-037-2012(AR) & A10A-036-2012(AR), E...

State: Arkansas

Filing Company: CMFG Life Insurance Company

TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: CMFG 2012 UT80/UT80EZ

Project Name/Number: CMFG 2012 UT80/UT80EZ /

Filing at a Glance

Company: CMFG Life Insurance Company

Product Name: CMFG 2012 UT80/UT80EZ

State: Arkansas

TOI: L04I Individual Life - Term

Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium

Filing Type: Form

Date Submitted: 07/25/2012

SERFF Tr Num: CUNA-128479621

SERFF Status: Closed-Approved-Closed

State Tr Num:

State Status: Approved-Closed

Co Tr Num: A10A-037-2012(AR) & A10A-036-2012(AR), ET AL

Implementation: On Approval

Date Requested:

Author(s): Brenda Sievers, Kari Hamrick, Kathy Strauser, Kimberly Steggall, Nancy French

Reviewer(s): Linda Bird (primary)

Disposition Date: 08/21/2012

Disposition Status: Approved-Closed

Implementation Date:

State Filing Description:

State: Arkansas
TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: CMFG 2012 UT80/UT80EZ
Project Name/Number: CMFG 2012 UT80/UT80EZ /

Filing Company: CMFG Life Insurance Company

General Information

Project Name: CMFG 2012 UT80/UT80EZ
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Deemer Date:
Submitted By: Nancy French

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 06/29/2012
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 08/21/2012
State Status Changed: 08/02/2012
Created By: Nancy French
Corresponding Filing Tracking Number:

Filing Description:
TO: Arkansas Department of Insurance

RE: CMFG Life Insurance Company
NAIC # 62626

Individual Term Life Forms:
Form A10a-036-2012(AR) – Individual Term Life Policy To Age 80
Form A10a-037-2012(AR) – Individual Term Life Policy To Age 80
Form A10f-036(J)-2012 – Individual Term Life Application
Form A10f-037(J)-2012 – Individual Term Life Application
Form A10ad-ADB-2012 – Individual Accidental Death Benefit Rider
Form A10fd-ADB-2012 – Individual Accidental Death Benefit Rider Application
Form ENDORSE-2012 – Individual Application Endorsement
Form AMEND-2012 – Individual Life Application Amendment

Dear Sir or Madam:

The forms included in this filing are being submitted for your review and approval. These forms are new forms, and do not replace any existing forms. This submission contains no unusual or possibly controversial items from normal company or industry standards. The policy forms are in final print with the exception of ink, font style, paper stock and logo. The substance of the application forms is also final. However, in addition to changes in the ink, font style, paper stock and logo, these applications may be reformatted, sections rearranged, and the colors, shading and highlighting may be revised for direct mail marketing purposes. The application endorsement and application amendment are dynamic forms. Only the information pertaining to the insured will print on these forms. We hereby certify that any change or modification to a variable item will be administered in accordance with the Variability of Information section (except as noted here and in the attached Statement of Variability for ease of administration of Direct Mail products) including any requirements for prior approval of a change or modification.

These products provide Term Life Insurance benefits to age 80 and are non-illustrative. These products will be marketed via direct response method, which includes marketing over the telephone through our call center and through the mail via a direct mail kit. The filed application forms will be included in a marketing piece within the direct mail marketing kit. The filed application forms, when placed within the marketing piece, will always include the filed application form number, and the marketing piece will have its own separate form number.

State: Arkansas
TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: CMFG 2012 UT80/UT80EZ
Project Name/Number: CMFG 2012 UT80/UT80EZ /

Policy forms A10a-036-2012 and A10a-037-2012 both provide indeterminate term coverage to age 80. The only difference between these policy forms is the face amount and issue age ranges. These policy forms are sex-distinct and will not be issued in any employer-employee plans that are subject to the Norris decision and/or Title VII of the Civil Rights Act of 1964.

Rider form A10ad-ADB-2012 provides accidental death benefit protection and can be used with either policy, as well as with any other individual life policy approved by the department.

Application form A10fd-ADB-2012 will be used to add the accidental death benefit rider to a previously issued policy. This application will be used only by call center agents. Application form A10f-036(J)-2012 will be used with policy form A10a-036-2012. Application form A10f-037(J)-2012 will be used with policy form A10a-037-2012. In order to keep the application process as simple as possible, which is critical to the direct mail process, there is no separate Owner Section on these applications. Please note that these products are not marketed to juveniles, so an owner other than the applicant is not a requirement. Once issued, a change of ownership is permitted as described in the policy forms. Upon approval of these application forms, in addition to being available in a paper application form, these applications may be made available through a secured site on the internet where agents and home office personnel have the option to complete fields within the application on-line for marketing over the telephone via our call center. The application (which has been populated with the information obtained over the telephone) will then be printed on paper and mailed to the applicant for a wet signature, or an electronic voice signature will be applied to the application. Electronic signatures will be captured in accordance with UETA and ESIGN regulations. Once the electronic signature is applied and embedded into the document it is locked down so that changes cannot occur. In the event the application is completed over the telephone by an agent, we hereby certify that the appropriate agent replacement question/existing insurance question will be asked in a form other than the application.

Forms ENDORSE-2012 and AMEND-2012 will be used during the underwriting process to make changes to the information provided on the application. These forms can be used with either application as well as with any other individual life application approved by the department.

These forms were written to be readable and easily understood by insureds. Each of these forms achieved a flesch score of more than 50.

Thank you for your review of these policy forms. If you have any questions please feel free to call me at 513-984-6050 or e-mail me at nfrench@crssolutionsgroup.com.

Sincerely,

Nancy L. French
Project Manager

Company and Contact

Filing Contact Information

Nancy French,
10921 Reed Hartman Highway,
Suite 334
Cincinnati, OH 45242

nfrench@crssolutionsgroup.com
513-984-6050 [Phone]

SERFF Tracking #: CUNA-128479621

State Tracking #:

Company Tracking #: A10A-037-2012(AR) & A10A-036-2012(AR), E...

State: Arkansas

Filing Company: CMFG Life Insurance Company

TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name: CMFG 2012 UT80/UT80EZ

Project Name/Number: CMFG 2012 UT80/UT80EZ /

Filing Company Information

CMFG Life Insurance Company

CoCode: 62626

State of Domicile: Iowa

2000 Heritage Way

Group Code: 306

Company Type:

Waverly, IA 50677

Group Name:

State ID Number:

(319) 352-4090 ext. [Phone]

FEIN Number: 39-0230590

Filing Fees

Fee Required?

Yes

Fee Amount:

\$500.00

Retaliatory?

No

Fee Explanation:

\$50 x 8 forms and 2 rates = \$500

Per Company:

No

Company

Amount

Date Processed

Transaction

CMFG Life Insurance Company

\$500.00

07/25/2012

61167872

SERFF Tracking #:	CUNA-128479621	State Tracking #:		Company Tracking #:	A10A-037-2012(AR) & A10A-036-2012(AR), E...
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State:	Arkansas	Filing Company:	CMFG Life Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	CMFG 2012 UT80/UT80EZ		
Project Name/Number:	CMFG 2012 UT80/UT80EZ /		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/21/2012	08/21/2012
Approved-Closed	Linda Bird	08/02/2012	08/02/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Linda Bird	08/02/2012	08/02/2012

Response Letters

Responded By	Created On	Date Submitted
Nancy French	08/02/2012	08/02/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Individual Life Application Amendment	Nancy French	08/17/2012	08/17/2012
Supporting Document	Statement of Variability	Nancy French	08/17/2012	08/17/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Please re open	Note To Filer	Linda Bird	08/17/2012	08/17/2012
Please re open	Note To Reviewer	Nancy French	08/15/2012	08/15/2012

State:	Arkansas	Filing Company:	CMFG Life Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	CMFG 2012 UT80/UT80EZ		
Project Name/Number:	CMFG 2012 UT80/UT80EZ /		

Disposition

Disposition Date: 08/21/2012

Implementation Date:

Status: Approved-Closed

Comment: Corrections made to the original submission.

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
CMFG Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

State:	Arkansas	Filing Company:	CMFG Life Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	CMFG 2012 UT80/UT80EZ		
Project Name/Number:	CMFG 2012 UT80/UT80EZ /		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Authorization		Yes
Supporting Document (revised)	Statement of Variability		Yes
Supporting Document	Statement of Variability	Replaced	Yes
Supporting Document	987AR 0212		Yes
Supporting Document	AR Cert of Comp with Rule 19 & 49		Yes
Form	Individual Term Life Policy To Age 80		Yes
Form	Individual Term Life Policy To Age 80		Yes
Form	Individual Term Life Application		Yes
Form	Individual Term Life Application		Yes
Form	Individual Accidental Death Benefit Rider		Yes
Form	Individual Accidental Death Benefit Rider Application		Yes
Form	Individual Application Endorsement		Yes
Form (revised)	Individual Life Application Amendment		Yes
Form	Individual Life Application Amendment	Replaced	Yes
Rate	Rate Sheet		Yes
Rate	Rate Sheet		Yes

State:	Arkansas	Filing Company:	CMFG Life Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	CMFG 2012 UT80/UT80EZ		
Project Name/Number:	CMFG 2012 UT80/UT80EZ /		

Disposition

Disposition Date: 08/02/2012

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
CMFG Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

State:	Arkansas	Filing Company:	CMFG Life Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	CMFG 2012 UT80/UT80EZ		
Project Name/Number:	CMFG 2012 UT80/UT80EZ /		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Authorization		Yes
Supporting Document (revised)	Statement of Variability		Yes
Supporting Document	Statement of Variability	Replaced	Yes
Supporting Document	987AR 0212		Yes
Supporting Document	AR Cert of Comp with Rule 19 & 49		Yes
Form	Individual Term Life Policy To Age 80		Yes
Form	Individual Term Life Policy To Age 80		Yes
Form	Individual Term Life Application		Yes
Form	Individual Term Life Application		Yes
Form	Individual Accidental Death Benefit Rider		Yes
Form	Individual Accidental Death Benefit Rider Application		Yes
Form	Individual Application Endorsement		Yes
Form (revised)	Individual Life Application Amendment		Yes
Form	Individual Life Application Amendment	Replaced	Yes
Rate	Rate Sheet		Yes
Rate	Rate Sheet		Yes

State: Arkansas
TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: CMFG 2012 UT80/UT80EZ
Project Name/Number: CMFG 2012 UT80/UT80EZ /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/02/2012
Submitted Date	08/02/2012
Respond By Date	09/04/2012

Dear Nancy French,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

Comments:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

Regulation 49 requires that a Life and Health guaranty notice be given to each policy owner. Please review your issue procedures and assure us that you are in compliance with Regulation 49.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of the Department.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

State:	Arkansas	Filing Company:	CMFG Life Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	CMFG 2012 UT80/UT80EZ		
Project Name/Number:	CMFG 2012 UT80/UT80EZ /		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/02/2012
Submitted Date	08/02/2012

Dear Linda Bird,

Introduction:

Thank you for your message regarding the Notice and Certification requirements for this filing.

Response 1

Comments:

We have attached to the Supporting Documentation tab a copy of the notice, 987AR 0212, required by Ark. Code Ann. 23-79-138. A copy will accompany every policy issued in Arkansas.

We have also attached to the Supporting Documentation tab a certificate of compliance with Regulation 49 & 19.

Related Objection 1

Comments:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

Regulation 49 requires that a Life and Health guaranty notice be given to each policy owner. Please review your issue procedures and assure us that you are in compliance with Regulation 49.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of the Department.

Changed Items:

Supporting Document Schedule Item Changes
Satisfied -Name: 987AR 0212
Comment:
Satisfied -Name: AR Cert of Comp with Rule 19 & 49
Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

SERFF Tracking #:	CUNA-128479621	State Tracking #:		Company Tracking #:	A10A-037-2012(AR) & A10A-036-2012(AR), E...
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State:	Arkansas	Filing Company:	CMFG Life Insurance Company
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Product Name:	CMFG 2012 UT80/UT80EZ		
Project Name/Number:	CMFG 2012 UT80/UT80EZ /		

Conclusion:

Thank you for your continued review of this filing.

Sincerely,

Nancy French

SERFF Tracking #:	CUNA-128479621	State Tracking #:		Company Tracking #:	A10A-037-2012(AR) & A10A-036-2012(AR), E...
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State:	Arkansas	Filing Company:	CMFG Life Insurance Company		
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium				
Product Name:	CMFG 2012 UT80/UT80EZ				
Project Name/Number:	CMFG 2012 UT80/UT80EZ /				

Amendment Letter

Submitted Date: 08/17/2012

Comments:

Thank you for reopening this filing.

We are attaching a revised form 2012-AMEND. Upon further review we determined that some wording was incorrect, and some brackets were missing from the form. The Statement of Variables for forms 2012-AMEND has been updated for consistency; and we are also attaching an updated Statement of Variability for Form 2012-ENDORSE to include some additional variables that are needed for service requests. We apologize for these oversights in the original form and Statements of Variability.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AMEND-2012	Application/Enrollment Form	Individual Life Application Amendment	Initial				61.000	AMEND-2012(REV).pdf

Supporting Document Schedule Item Changes:

User Added -Name: Statement of Variability

Comment:

SoV A10a-036-2012 et al.pdf

AMEND-2012 SoV(REV).pdf

ENDORSE-2012 SoV(REV).pdf

SERFF Tracking #: CUNA-128479621

State Tracking #:

Company Tracking #: A10A-037-2012(AR) & A10A-036-2012(AR), E...

State: Arkansas

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Product Name: CMFG 2012 UT80/UT80EZ

Project Name/Number: CMFG 2012 UT80/UT80EZ /

Note To Filer

Created By:

Linda Bird on 08/17/2012 09:52 AM

Last Edited By:

Linda Bird

Submitted On:

08/17/2012 09:52 AM

Subject:

Please re open

Comments:

Filing has been re-opened in order for correction to be made.

SERFF Tracking #: CUNA-128479621

State Tracking #:

Company Tracking #: A10A-037-2012(AR) & A10A-036-2012(AR), E...

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Product Name: CMFG 2012 UT80/UT80EZ

Project Name/Number: CMFG 2012 UT80/UT80EZ /

Note To Reviewer

Created By:

Nancy French on 08/15/2012 04:26 PM

Last Edited By:

Nancy French

Submitted On:

08/15/2012 04:26 PM

Subject:

Please re open

Comments:

We respectfully request that this filing be reopened so that we may provide a revision to a form in this filing Thank you

State:	Arkansas	Filing Company:	CMFG Life Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	CMFG 2012 UT80/UT80EZ		
Project Name/Number:	CMFG 2012 UT80/UT80EZ /		

Form Schedule

Lead Form Number: A10a-036-2012(AR)							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		A10a-036-2012(AR)	POL	Individual Term Life Policy To Age 80	Initial:	56.000	A10a-036-2012(AR).pdf
2		A10a-037-2012(AR)	POL	Individual Term Life Policy To Age 80	Initial:	56.000	A10a-037-2012(AR).pdf
3		A10f-036(J)-2012	AEF	Individual Term Life Application	Initial:	61.000	A10f-036(J)-2012.pdf
4		A10f-037(J)-2012	AEF	Individual Term Life Application	Initial:	57.000	A10f-037(J)-2012.pdf
5		A10ad-ADB-2012	POLA	Individual Accidental Death Benefit Rider	Initial:	54.000	A10ad-ADB-2012.pdf
6		A10fd-ADB-2012	AEF	Individual Accidental Death Benefit Rider Application	Initial:	63.000	A10fd-ADB-2012.pdf
7		ENDORSE-2012	AEF	Individual Application Endorsement	Initial:	60.000	ENDORSE-2012.pdf
8		AMEND-2012	AEF	Individual Life Application Amendment	Initial:	61.000	AMEND-2012(REV).pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage

SERFF Tracking #:	CUNA-128479621	State Tracking #:		Company Tracking #:	A10A-037-2012(AR) & A10A-036-2012(AR), E...
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PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



CMFG Life Insurance Company

P.O. Box 61 • 2000 Heritage Way
Waverly, IA 50677-0061
Phone: 800.779.5433

TERM LIFE INSURANCE POLICY TO AGE 80

READ YOUR CONTRACT CAREFULLY. This is a legal contract between the owner and CMFG Life Insurance Company, and hereafter will be referred to as the policy.

This policy is issued to the owner in consideration of the application and premium payment. CMFG Life Insurance Company will pay the benefits of this policy, subject to its terms and conditions, which will never be less than the amount required by state law.

POLICY SCHEDULE

INSURED: [John Doe]	FACE AMOUNT: [\$1,000.00]
OWNER: [John Doe]	
RIDERS: [Accidental Death Benefit Rider]	[ACCIDENTAL DEATH AMOUNT:] [\$5,000.00]
POLICY NUMBER: [12345678]	ISSUE AGE: [35]
EFFECTIVE DATE: [4/1/2007]	SEX: [Male]
FINAL CONVERSION DATE: [4/1/2052]	PREMIUM CLASS: [Standard]

INITIAL CURRENT PREMIUM:	Monthly Automatic Payment	Monthly Direct Bill	Quarterly Direct Bill	Semi-Annual Direct Bill	Annual Direct Bill
Initial Term to 80 Premium:*	\$0.58	\$0.64	\$1.80	\$3.53	\$6.86
ADB Rider Premium:	\$0.40	\$0.45	\$1.25	\$2.45	\$4.75
TOTAL INITIAL PREMIUM:	\$0.98	\$1.09	\$3.05	\$5.98	\$11.61

* See the Premium Table at the end of the Policy for the entire schedule of premiums. Premiums will not exceed the Guaranteed Maximum. A change in premium, if any, will take effect on your policy anniversary.

TABLE OF CONTENTS

Policy Schedule.....	Cover Page	Conversion Privilege	Part 5
Right to Examine Policy	Cover Page	Beneficiary.....	Part 6
Definitions.....	Part 1	Owner.....	Part 7
Premiums	Part 2	General Provisions.....	Part 8
Coverage Provided	Part 3	Premium Table.....	Part 9
Payment of Proceeds.....	Part 4		

YOUR RIGHT TO EXAMINE THIS POLICY FOR 30 DAYS: You may return the policy to us for any reason and get a refund within 30 days of: (1) The date you received the policy or, if later, (2) The date we receive the initial premium. We will refund any premiums paid, including any fees or charges. The policy will be void from the start and will be treated as if it had not been issued.

Signed for CMFG Life Insurance Company on the effective date.

President

Secretary

TERM LIFE INSURANCE POLICY TO AGE 80

Renewable Annually.

Premiums Are Subject To Premium Change Provision.

Convertible To Insured's Age 80 Policy Anniversary.

Non-Participating.

PART 1: DEFINITIONS

1.01 What are the most commonly used terms and what do they mean?

age - The insured's age at his or her last birthday. An insured's age under his or her policy will be increased by one year on each policy anniversary thereafter.

beneficiary - The person(s) (or entities) who will receive the death proceeds due to the insured's death. An irrevocable beneficiary is a beneficiary who has certain rights that cannot be changed unless he or she consents to the change.

legal partner – The person with whom you have entered into a legally-sanctioned same-sex marriage, domestic partnership or civil union that grants you the same rights, responsibilities, and obligations as opposite-sex married couples in accordance with applicable state laws. We will not recognize a partner relationship in any state that does not legally recognize such relationship.

owner - The person who owns the policy as shown by our records and can exercise all the rights allowed by the policy during the insured's lifetime. The insured shown on the policy schedule is the owner unless otherwise specified at the time of application or later changed.

policy anniversary - The same day and month as the effective date for each succeeding year your policy remains in force.

policy year - Any twelve-month period beginning on the policy issue date or on a policy anniversary and ending one day before the next policy anniversary.

proof of death – Proof of death satisfactory to us. Such proof will consist of a certified copy of the death certificate of the insured, or other lawful evidence providing equivalent information and proof of the claimant's interest in the proceeds.

we, our, us – CMFG Life Insurance Company.

written request – A signed and dated written notice in a form satisfactory to us and received by us at our administrative office.

you, your, yours - The person named as the owner on the policy schedule.

PART 2: PREMIUMS

2.01 What are the premiums for your coverage?

The initial current premium is shown on your policy schedule. The current and guaranteed maximum premiums for all years are shown in the Premium Table (See Part 9). Premiums shown in the Premium Table do not include any rider premiums.

Premiums are based on the insured's attained age on your policy anniversary and will increase as shown in the Premium Table. Premiums that are paid other than annually may contain an additional modal expense factor.

2.02 Can the schedule of current premium rates be changed?

The schedule of current premium rates shown in the premium table are the premiums we are currently charging for insured's of the same age, sex and premium class. These current premiums may change, based on future expectations for such factors as: investment earnings, mortality, persistency, and expenses, but will never be more than the guaranteed maximum premiums shown. We will not change your current premiums because of a change in the insured's health or occupation. A change in premium, if any, will take effect on your policy anniversary. You will receive advance notice from us regarding any change in your premium. A change in the premium for this policy, if any, will have no effect on any attached riders.

2.03 When are premiums due and where are premiums paid?

All premiums must be paid during the insured's lifetime and received by us on or before the date they are due. The initial premium is due us on the effective date of insurance. Successive premiums are due us on the first day of each successive modal period. Premiums must be paid to us at our designated office.

2.04 Can the premium be paid after the date it is due?

You have 31 days beyond the due date to pay your premium. Your policy will continue in force during the grace period. Your premium, however, must be received by us within this 31-day grace period. If the insured dies during this period, we will deduct the premium for this 31-day grace period from the death proceeds. This 31-day grace period does not apply to the initial premium payment.

2.05 What happens if a premium is not paid before the end of the grace period?

If a premium is not paid before the end of the 31-day grace period, the coverage will lapse. You may, however, ask us to reinstate the coverage within 5 years after its lapse. In order to do so, we will require the following: (a) Your written request for reinstatement during the insured's lifetime; (b) Evidence of insurability which is satisfactory to us; and (c) Payment of all past due premiums plus interest at 4% per year.

PART 3: COVERAGE PROVIDED

3.01 What is the coverage provided by this policy?

This policy provides term life insurance with a level death benefit to age 80. It provides a death benefit to your beneficiary if the insured dies while covered under this policy.

3.02 Can the coverage be renewed?

Coverage can be renewed annually on your policy anniversary provided: (a) The insured's age on the date of renewal is less than 80; and (b) Premiums have been paid to your current policy anniversary; and (c) We receive payment of the renewal premium by the end of the 31-day grace period following your current policy anniversary.

3.03 When will insurance coverage begin?

The coverage provided by this policy takes effect only after the following: (a) We receive and approve your written application; and (b) We have received the initial premium. Coverage on the insured then takes effect on the date shown on the policy schedule.

If we do not receive an initial premium with the application, you have 21 days from the effective date shown on the policy schedule and during the insured's lifetime to pay such premium. There is no insurance in effect until we receive your initial premium. If this initial premium is not paid within this 21 day period, your policy will be deemed void and your application for insurance will be deemed withdrawn.

3.04 When will insurance coverage end?

The coverage provided by this policy will end automatically on the earliest of:

- a.) The date of the insured's death;
- b.) The date your policy lapses due to nonpayment of the required premium;
- c.) The policy anniversary on or next following the insured's 80th birthday;
- d.) The date you convert to an individual permanent life insurance policy; or
- e.) Upon your written request to terminate coverage.

PART 4: PAYMENT OF PROCEEDS

4.01 How are the death proceeds calculated?

The amount payable to the beneficiary will be determined as of the date of the insured's death. It is the total of: (a) The face amount shown on the policy schedule; (b) Plus any premium paid beyond the date of death; (c) Minus any premium due.

4.02 How and when will the proceeds be paid?

The death proceeds will be payable to the beneficiary on file at our administrative office when we receive proof of death. The proceeds will be paid in a single sum unless an optional mode of settlement has been selected. Payment is subject to the rights of any assignee of record.

We will pay interest on single sum death proceeds, if required by state law. Interest will be calculated at the effective rate and for the time period required under applicable law.

4.03 What are the optional modes of settlement?

There are two optional modes of settlement available for payment of proceeds. They are described below. Other methods of payment may be available upon agreement between you and us. The minimum amount which can be applied under these options is the greater of \$5,000, or the amount required to provide monthly payments of \$50. Other options may be available with our consent. If an optional mode of settlement is not selected before your death, your beneficiary may make such selection by written request.

The rates shown in the tables below are used to determine the minimum monthly payments. If higher current rates are applicable, they will be provided upon request.

Option 1 - Installment Option. We will pay equal monthly payments for a chosen number of years, not less than 5 nor more than 30. If the original payee (your beneficiary) dies before payments have been made for the chosen number of years:

- 1.) payments will be continued for the remainder of the period to the successor payee; or
- 2.) the present value of the remaining payments, computed at the interest rate used to create the Option 1 rates, will be paid to the successor payee or to the last surviving payee's estate, if there is no successor payee.

The amount of each monthly payment for each \$1,000 of proceeds applied under this option is shown in the following table:

<u>Number of Years</u>	<u>Monthly Payment</u>
5	17.49
10	9.18
15	6.42
20	5.04
25	4.22
30	3.68

The Option 1 rates are based on 2% interest per year.

Option 2 – Life Income - Specified Guarantee Period Certain. We will pay monthly payments for as long as the payee lives. We will require satisfactory proof of the payee's age and gender. If the original payee (your beneficiary) dies before all of the payments have been made for the specified guaranteed period certain:

- 1.) payments will be continued during the remainder of the guaranteed period certain to the successor payee; or
- 2.) the present value of the remaining payments, computed at the interest rate used to create the Option 2 rates, will be paid to the successor payee or to the last surviving payee's estate, if there is no successor payee.

The specified guaranteed period certain choices are:

- 1.) 0 years (life income only);
- 2.) 10 years; or
- 3.) 20 years.

The amount of each monthly payment for each \$1,000 of proceeds applied under this option is shown in the following table:

Years	MALE					FEMALE				
	Ages					Ages				
	55	60	65	70	75	55	60	65	70	75
0	3.90	4.42	5.12	6.10	7.44	3.60	4.04	4.63	5.46	6.66
10	3.86	4.34	4.95	5.70	6.57	3.58	4.00	4.54	5.25	6.16
20	3.70	4.04	4.38	4.68	4.88	3.49	3.83	4.20	4.56	4.83

These monthly payments are based on the Annuity 2000 Mortality Tables with compound interest at an effective rate of 2%. Monthly payments for any period or age not shown, if allowed by us, will be calculated on an actuarially equivalent basis and will be furnished upon request.

PART 5: CONVERSION PRIVILEGE

5.01 Can coverage be converted to a permanent life insurance policy?

You may elect to convert the amount of coverage under your policy provided:

- a.) Your written request is made on or before the final conversion date shown on your policy schedule;
- b.) Your coverage is in force; and
- c.) The new policy is a permanent life insurance policy that is available to be issued at the insured's age at the time of conversion.

The effective date of conversion will be the premium due date following receipt of your written request to convert. The conversion date will be the issue date of your new policy. The suicide and incontestability provision for your new policy will be measured from the effective date of this policy.

5.02 What amount can be converted?

Any amount up to or equal to the face amount of your policy may be converted. However, the face amount to be converted must be at least equal to the minimum face amount we require to issue the new permanent life insurance policy.

5.03 What basis will be used to determine the premium for the new policy?

The premium will be based on the insured's age at the time of conversion and on the insured's gender and premium class. The premium class for the new policy will be the same premium class as this policy. If the same premium class is not available, the premium class will be a comparable premium class, as determined by us.

The premium for the new policy is due on the conversion date.

- 5.04 Will evidence of insurability be required?** Evidence of insurability will not be required unless you request an additional benefit rider that we make available for issue with the new policy. If you request an additional benefit rider with the new policy which was not included in this policy, we will require evidence of insurability which is satisfactory to us. Any additional benefit rider will be contestable for a two year period based on evidence given in the additional benefit rider application.

PART 6: BENEFICIARY

- 6.01 Who is the beneficiary?** The beneficiary is named on your application, unless later changed as allowed by this policy. If there is no named beneficiary when the insured dies, death proceeds will be paid to your spouse or legal partner, if living, otherwise to your estate.
- 6.02 Are there different classes of beneficiaries?** There are different classes of beneficiaries called primary and contingent. These classes set the order of payment. There may be more than one beneficiary in a class. Beneficiaries in the same class will receive equal payments unless we have other written instructions to the contrary. If no primary beneficiary outlives the insured, the death proceeds will be paid to the contingent beneficiary. If no primary or contingent outlives the insured, the death proceeds will be paid to your spouse or legal partner, if living otherwise to your estate.
- 6.03 Can the beneficiary be changed?** You can change your beneficiary at any time by written request, unless you indicate that the beneficiary cannot be changed without the beneficiary's consent (an irrevocable beneficiary). The written consent of each irrevocable beneficiary, and assignee, if any, will be required as part of such written request.
- A request for change of beneficiary will, unless otherwise specified by you, take effect as of the date you signed the request. However, we will not be responsible for any payment made or other action taken before we record the request.

PART 7: OWNER

- 7.01 Who is the owner?** The insured is the owner unless it is otherwise specified in the application or subsequently changed as allowed under this policy. All the rights allowed under the policy may be exercised solely by the owner.
- If the insured is not the owner, ownership will pass automatically to the insured on the date of the owner's death. The change will take effect on the date we receive due proof of death.
- 7.02 What are the owner's rights and how does he or she exercise his or her rights?** Ownership rights include changing ownership, changing beneficiaries, assigning the policy, and exercising all other rights and privileges allowed by the policy. Ownership rights may be exercised only during the insured's lifetime by written request.
- 7.03 How is ownership of this policy changed?** A change of owner may be made at any time before the insured's death by written request, which must include the written consent of each irrevocable beneficiary and assignee, if any. Such written request, unless otherwise specified by you, will take effect as of the date the request was signed. However, we will not be responsible for any action taken before we record the request.

PART 8: GENERAL PROVISIONS

- 8.01 What does the entire contract consist of?**
- This policy, your application, any supplemental application, and any endorsement(s), amendments or rider(s) make up the entire contract.
- No one except a company officer can change or give up any of the rights or requirements in this policy. Any change must be in writing.
- We will accept statements made in the application, in the absence of fraud, to be representations and not warranties. No statement will be used by us to contest a claim, unless it is contained in your application.
- 8.02 When does your policy become incontestable?**
- Except after reinstatement, we cannot contest this policy or any attached rider after it has been in force during the insured's lifetime for a period of two years from the effective date except for failure to pay premiums or fraud. Any addition of a rider after the effective date shall be incontestable, after it has been in force during the insured's lifetime for two years after the effective date of such addition of rider, except as to fraud. We may contest this policy or any rider on the basis of any material misrepresentation in the application, supplemental application, reinstatement application or other document signed by you that becomes part of the policy.
- 8.03 What if the insured's age or sex has been misstated?**
- If the insured's age or sex is misstated, we will adjust the amount payable and other benefits. This adjustment will be based on what the premium would have purchased at the correct age or sex. If the correct age is not within the issue age range for this policy, a premium and benefits will be extrapolated.
- 8.04 Can your benefits be assigned?**
- You may assign the benefits provided by this policy. In order for us to honor the assignment, we must receive notice of your assignment which includes your signature as well as that of each irrevocable beneficiary. Assignments, unless otherwise specified by you, will take effect on the date the notice of assignment is signed by you, subject to any payments made or action taken by us prior to receipt of notice. We are not responsible for the validity or effect of the assignment.
- 8.05 Is there a reduction in benefits for deaths caused by suicide?**
- Suicide by the insured, while sane or insane, within two years of the policy effective date will result in a reduced death benefit. If the insured dies by suicide during this two year period, the death proceeds payable to your beneficiary will be limited to the premiums paid (including any rider premiums), reduced by any indebtedness.

PART 9: PREMIUM TABLE**INSURED:** [John Doe]**PREMIUM CLASS:** [Standard]

The premiums we charge will never be more than the guaranteed maximum premiums shown (See Part 2). The premiums shown do not include any rider premiums.

POLICY YEAR	AGE BEGINNING OF POLICY YEAR	CURRENT ANNUAL PREMIUM	GUARANTEED MAXIMUM ANNUAL PREMIUM
(01)	(35)	(\$6.86)	(\$9.02)
02	36	\$6.86	\$9.02
03	37	\$6.86	\$9.02
04	38	\$6.86	\$9.02
05	39	\$6.86	\$9.02
06	40	\$8.89	\$13.37
07	41	\$8.89	\$13.37
08	42	\$8.89	\$13.37
09	43	\$8.89	\$13.37
10	44	\$8.89	\$13.37
11	45	\$11.79	\$20.69
12	46	\$11.79	\$20.69
13	47	\$11.79	\$20.69
14	48	\$11.79	\$20.69
15	49	\$11.79	\$20.69
16	50	\$15.12	\$30.61
17	51	\$15.12	\$30.61
18	52	\$15.12	\$30.61
19	53	\$15.12	\$30.61
20	54	\$15.12	\$30.61
21	55	\$21.74	\$50.92
22	56	\$21.74	\$50.92
23	57	\$21.74	\$50.92
24	58	\$21.74	\$50.92
25	59	\$21.74	\$50.92
26	60	\$30.15	\$83.53
27	61	\$30.15	\$83.53
28	62	\$30.15	\$83.53
29	63	\$30.15	\$83.53
30	64	\$30.15	\$83.53
31	65	\$41.68	\$134.46
32	66	\$41.68	\$134.46
33	67	\$41.68	\$134.46
34	68	\$41.68	\$134.46
35	69	\$41.68	\$134.46
36	70	\$75.61	\$210.57
37	71	\$75.61	\$210.57
38	72	\$75.61	\$210.57
39	73	\$75.61	\$210.57
40	74	\$75.61	\$210.57
41	75	\$144.46	\$342.99
42	76	\$144.46	\$342.99
43	77	\$144.46	\$342.99
44	78	\$144.46	\$342.99
(45)	(79)	(\$144.46)	(\$342.99)



CMFG Life Insurance Company

P.O. Box 61 • 2000 Heritage Way
Waverly, IA 50677-0061
Phone: 800.779.5433

TERM LIFE INSURANCE POLICY TO AGE 80

READ YOUR CONTRACT CAREFULLY. This is a legal contract between the owner and CMFG Life Insurance Company, and hereafter will be referred to as the policy.

This policy is issued to the owner in consideration of the application and premium payment. CMFG Life Insurance Company will pay the benefits of this policy, subject to its terms and conditions, which will never be less than the amount required by state law.

POLICY SCHEDULE

INSURED: [John Doe]	FACE AMOUNT: [\$25,000.00]
OWNER: [John Doe]	
RIDERS: [Accidental Death Benefit Rider]	[ACCIDENTAL DEATH AMOUNT:] [\$50,000.00]
POLICY NUMBER: [12345678]	ISSUE AGE: [35]
EFFECTIVE DATE: [4/1/2007]	SEX: [Male]
FINAL CONVERSION DATE: [4/1/2052]	PREMIUM CLASS: [Standard Non-Tobacco]

INITIAL CURRENT PREMIUM:	Monthly Automatic Payment	Monthly Direct Bill	Quarterly Direct Bill	Semi-Annual Direct Bill	Annual Direct Bill
Initial Term to 80 Premium:*	\$5.25	\$5.75	\$16.50	\$32.50	\$63.25
ADB Rider Premium:	\$4.00	\$4.50	\$12.50	\$24.50	\$47.50
TOTAL INITIAL PREMIUM:	\$9.25	\$10.25	\$29.00	\$57.00	\$110.75

* See the Premium Table at the end of the Policy for the entire schedule of premiums. Premiums will not exceed the Guaranteed Maximum. A change in premium, if any, will take effect on your policy anniversary.

TABLE OF CONTENTS

Policy Schedule.....	Cover Page	Conversion Privilege	Part 5
Right to Examine Policy	Cover Page	Beneficiary.....	Part 6
Definitions.....	Part 1	Owner.....	Part 7
Premiums	Part 2	General Provisions.....	Part 8
Coverage Provided	Part 3	Premium Table.....	Part 9
Payment of Proceeds.....	Part 4		

YOUR RIGHT TO EXAMINE THIS POLICY FOR 30 DAYS: You may return the policy to us for any reason and get a refund within 30 days of: (1) The date you received the policy or, if later, (2) The date we receive the initial premium. We will refund any premiums paid, including any fees or charges. The policy will be void from the start and will be treated as if it had not been issued.

Signed for CMFG Life Insurance Company on the effective date.

President

Secretary

TERM LIFE INSURANCE POLICY TO AGE 80

Renewable Annually.

Premiums Are Subject To Premium Change Provision.

Convertible To Insured's Age 80 Policy Anniversary.

Non-Participating.

PART 1: DEFINITIONS

1.01 What are the most commonly used terms and what do they mean?

age - The insured's age at his or her last birthday. An insured's age under his or her policy will be increased by one year on each policy anniversary thereafter.

beneficiary - The person(s) (or entities) who will receive the death proceeds due to the insured's death. An irrevocable beneficiary is a beneficiary who has certain rights that cannot be changed unless he or she consents to the change.

legal partner – The person with whom you have entered into a legally-sanctioned same-sex marriage, domestic partnership or civil union that grants you the same rights, responsibilities, and obligations as opposite-sex married couples in accordance with applicable state laws. We will not recognize a partner relationship in any state that does not legally recognize such relationship.

owner - The person who owns the policy as shown by our records and can exercise all the rights allowed by the policy during the insured's lifetime. The insured shown on the policy schedule is the owner unless otherwise specified at the time of application or later changed.

policy anniversary - The same day and month as the effective date for each succeeding year your policy remains in force.

policy year - Any twelve-month period beginning on the policy issue date or on a policy anniversary and ending one day before the next policy anniversary.

proof of death – Proof of death satisfactory to us. Such proof will consist of a certified copy of the death certificate of the insured, or other lawful evidence providing equivalent information and proof of the claimant's interest in the proceeds.

we, our, us – CMFG Life Insurance Company.

written request – A signed and dated written notice in a form satisfactory to us and received by us at our administrative office.

you, your, yours - The person named as the owner on the policy schedule.

PART 2: PREMIUMS

2.01 What are the premiums for your coverage?

The initial current premium is shown on your policy schedule. The current and guaranteed maximum premiums for all years are shown in the Premium Table (See Part 9). Premiums shown in the Premium Table do not include any rider premiums.

Premiums are based on the insured's attained age on your policy anniversary and will increase as shown in the Premium Table. Premiums that are paid other than annually may contain an additional modal expense factor.

2.02 Can the schedule of current premium rates be changed?

The schedule of current premium rates shown in the premium table are the premiums we are currently charging for insured's of the same age, sex and premium class. These current premiums may change, based on future expectations for such factors as: investment earnings, mortality, persistency, and expenses, but will never be more than the guaranteed maximum premiums shown. We will not change your current premiums because of a change in the insured's health or occupation. A change in premium, if any, will take effect on your policy anniversary. You will receive advance notice from us regarding any change in your premium. A change in the premium for this policy, if any, will have no effect on any attached riders.

2.03 When are premiums due and where are premiums paid?

All premiums must be paid during the insured's lifetime and received by us on or before the date they are due. The initial premium is due us on the effective date of insurance. Successive premiums are due us on the first day of each successive modal period. Premiums must be paid to us at our designated office.

2.04 Can the premium be paid after the date it is due?

You have 31 days beyond the due date to pay your premium. Your policy will continue in force during the grace period. Your premium, however, must be received by us within this 31-day grace period. If the insured dies during this period, we will deduct the premium for this 31-day grace period from the death proceeds. This 31-day grace period does not apply to the initial premium payment.

2.05 What happens if a premium is not paid before the end of the grace period?

If a premium is not paid before the end of the 31-day grace period, the coverage will lapse. You may, however, ask us to reinstate the coverage within 5 years after its lapse. In order to do so, we will require the following: (a) Your written request for reinstatement during the insured's lifetime; (b) Evidence of insurability which is satisfactory to us; and (c) Payment of all past due premiums plus interest at 4% per year.

PART 3: COVERAGE PROVIDED

3.01 What is the coverage provided by this policy?

This policy provides term life insurance with a level death benefit to age 80. It provides a death benefit to your beneficiary if the insured dies while covered under this policy.

3.02 Can the coverage be renewed?

Coverage can be renewed annually on your policy anniversary provided: (a) The insured's age on the date of renewal is less than 80; and (b) Premiums have been paid to your current policy anniversary; and (c) We receive payment of the renewal premium by the end of the 31-day grace period following your current policy anniversary.

3.03 When will insurance coverage begin?

The coverage provided by this policy takes effect only after the following: (a) We receive and approve your written application; and (b) We have received the initial premium. Coverage on the insured then takes effect on the date shown on the policy schedule.

If we do not receive an initial premium with the application, you have 21 days from the effective date shown on the policy schedule and during the insured's lifetime to pay such premium. There is no insurance in effect until we receive your initial premium. If this initial premium is not paid within this 21 day period, your policy will be deemed void and your application for insurance will be deemed withdrawn.

3.04 When will insurance coverage end?

The coverage provided by this policy will end automatically on the earliest of:

- a.) The date of the insured's death;
- b.) The date your policy lapses due to nonpayment of the required premium;
- c.) The policy anniversary on or next following the insured's 80th birthday;
- d.) The date you convert to an individual permanent life insurance policy; or
- e.) Upon your written request to terminate coverage.

PART 4: PAYMENT OF PROCEEDS

4.01 How are the death proceeds calculated?

The amount payable to the beneficiary will be determined as of the date of the insured's death. It is the total of: (a) The face amount shown on the policy schedule; (b) Plus any premium paid beyond the date of death; (c) Minus any premium due.

4.02 How and when will the proceeds be paid?

The death proceeds will be payable to the beneficiary on file at our administrative office when we receive proof of death. The proceeds will be paid in a single sum unless an optional mode of settlement has been selected. Payment is subject to the rights of any assignee of record.

We will pay interest on single sum death proceeds, if required by state law. Interest will be calculated at the effective rate and for the time period required under applicable law.

4.03 What are the optional modes of settlement?

There are two optional modes of settlement available for payment of proceeds. They are described below. Other methods of payment may be available upon agreement between you and us. The minimum amount which can be applied under these options is the greater of \$5,000, or the amount required to provide monthly payments of \$50. Other options may be available with our consent. If an optional mode of settlement is not selected before your death, your beneficiary may make such selection by written request.

The rates shown in the tables below are used to determine the minimum monthly payments. If higher current rates are applicable, they will be provided upon request.

Option 1 - Installment Option. We will pay equal monthly payments for a chosen number of years, not less than 5 nor more than 30. If the original payee (your beneficiary) dies before payments have been made for the chosen number of years:

- 1.) payments will be continued for the remainder of the period to the successor payee; or
- 2.) the present value of the remaining payments, computed at the interest rate used to create the Option 1 rates, will be paid to the successor payee or to the last surviving payee's estate, if there is no successor payee.

The amount of each monthly payment for each \$1,000 of proceeds applied under this option is shown in the following table:

<u>Number of Years</u>	<u>Monthly Payment</u>
5	17.49
10	9.18
15	6.42
20	5.04
25	4.22
30	3.68

The Option 1 rates are based on 2% interest per year.

Option 2 – Life Income - Specified Guarantee Period Certain. We will pay monthly payments for as long as the payee lives. We will require satisfactory proof of the payee's age and gender. If the original payee (your beneficiary) dies before all of the payments have been made for the specified guaranteed period certain:

- 1.) payments will be continued during the remainder of the guaranteed period certain to the successor payee; or
- 2.) the present value of the remaining payments, computed at the interest rate used to create the Option 2 rates, will be paid to the successor payee or to the last surviving payee's estate, if there is no successor payee.

The specified guaranteed period certain choices are:

- 1.) 0 years (life income only);
- 2.) 10 years; or
- 3.) 20 years.

The amount of each monthly payment for each \$1,000 of proceeds applied under this option is shown in the following table:

Years	MALE					FEMALE				
	Ages					Ages				
	55	60	65	70	75	55	60	65	70	75
0	3.90	4.42	5.12	6.10	7.44	3.60	4.04	4.63	5.46	6.66
10	3.86	4.34	4.95	5.70	6.57	3.58	4.00	4.54	5.25	6.16
20	3.70	4.04	4.38	4.68	4.88	3.49	3.83	4.20	4.56	4.83

These monthly payments are based on the Annuity 2000 Mortality Tables with compound interest at an effective rate of 2%. Monthly payments for any period or age not shown, if allowed by us, will be calculated on an actuarially equivalent basis and will be furnished upon request.

PART 5: CONVERSION PRIVILEGE

5.01 Can coverage be converted to a permanent life insurance policy?

You may elect to convert the amount of coverage under your policy provided:

- a.) Your written request is made on or before the final conversion date shown on your policy schedule;
- b.) Your coverage is in force; and
- c.) The new policy is a permanent life insurance policy that is available to be issued at the insured's age at the time of conversion.

The effective date of conversion will be the premium due date following receipt of your written request to convert. The conversion date will be the issue date of your new policy. The suicide and incontestability provision for your new policy will be measured from the effective date of this policy.

5.02 What amount can be converted?

Any amount up to or equal to the face amount of your policy may be converted. However, the face amount to be converted must be at least equal to the minimum face amount we require to issue the new permanent life insurance policy.

5.03 What basis will be used to determine the premium for the new policy?

The premium will be based on the insured's age at the time of conversion and on the insured's gender and premium class. The premium class for the new policy will be the same premium class as this policy. If the same premium class is not available, the premium class will be a comparable premium class, as determined by us.

The premium for the new policy is due on the conversion date.

- 5.04 Will evidence of insurability be required?** Evidence of insurability will not be required unless you request an additional benefit rider that we make available for issue with the new policy. If you request an additional benefit rider with the new policy which was not included in this policy, we will require evidence of insurability which is satisfactory to us. Any additional benefit rider will be contestable for a two year period based on evidence given in the additional benefit rider application.

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- 6.01 Who is the beneficiary?** The beneficiary is named on your application, unless later changed as allowed by this policy. If there is no named beneficiary when the insured dies, death proceeds will be paid to your spouse or legal partner, if living, otherwise to your estate.
- 6.02 Are there different classes of beneficiaries?** There are different classes of beneficiaries called primary and contingent. These classes set the order of payment. There may be more than one beneficiary in a class. Beneficiaries in the same class will receive equal payments unless we have other written instructions to the contrary. If no primary beneficiary outlives the insured, the death proceeds will be paid to the contingent beneficiary. If no primary or contingent outlives the insured, the death proceeds will be paid to your spouse or legal partner, if living otherwise to your estate.
- 6.03 Can the beneficiary be changed?** You can change your beneficiary at any time by written request, unless you indicate that the beneficiary cannot be changed without the beneficiary's consent (an irrevocable beneficiary). The written consent of each irrevocable beneficiary, and assignee, if any, will be required as part of such written request.

A request for change of beneficiary will, unless otherwise specified by you, take effect as of the date you signed the request. However, we will not be responsible for any payment made or other action taken before we record the request.

PART 7: OWNER

- 7.01 Who is the owner?** The insured is the owner unless it is otherwise specified in the application or subsequently changed as allowed under this policy. All the rights allowed under the policy may be exercised solely by the owner.
- If the insured is not the owner, ownership will pass automatically to the insured on the date of the owner's death. The change will take effect on the date we receive due proof of death.
- 7.02 What are the owner's rights and how does he or she exercise his or her rights?** Ownership rights include changing ownership, changing beneficiaries, assigning the policy, and exercising all other rights and privileges allowed by the policy. Ownership rights may be exercised only during the insured's lifetime by written request.
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- This policy, your application, any supplemental application, and any endorsement(s), amendments or rider(s) make up the entire contract.
- No one except a company officer can change or give up any of the rights or requirements in this policy. Any change must be in writing.
- We will accept statements made in the application, in the absence of fraud, to be representations and not warranties. No statement will be used by us to contest a claim, unless it is contained in your application.
- 8.02 When does your policy become incontestable?**
- Except after reinstatement, we cannot contest this policy or any attached rider after it has been in force during the insured's lifetime for a period of two years from the effective date except for failure to pay premiums or fraud. Any addition of a rider after the effective date shall be incontestable, after it has been in force during the insured's lifetime for two years after the effective date of such addition of rider, except as to fraud. We may contest this policy or any rider on the basis of any material misrepresentation in the application, supplemental application, reinstatement application or other document signed by you that becomes part of the policy.
- 8.03 What if the insured's age or sex has been misstated?**
- If the insured's age or sex is misstated, we will adjust the amount payable and other benefits. This adjustment will be based on what the premium would have purchased at the correct age or sex. If the correct age is not within the issue age range for this policy, a premium and benefits will be extrapolated.
- 8.04 Can your benefits be assigned?**
- You may assign the benefits provided by this policy. In order for us to honor the assignment, we must receive notice of your assignment which includes your signature as well as that of each irrevocable beneficiary. Assignments, unless otherwise specified by you, will take effect on the date the notice of assignment is signed by you, subject to any payments made or action taken by us prior to receipt of notice. We are not responsible for the validity or effect of the assignment.
- 8.05 Is there a reduction in benefits for deaths caused by suicide?**
- Suicide by the insured, while sane or insane, within two years of the policy effective date will result in a reduced death benefit. If the insured dies by suicide during this two year period, the death proceeds payable to your beneficiary will be limited to the premiums paid (including any rider premiums).

PART 9: PREMIUM TABLE

INSURED: [John Doe]

PREMIUM CLASS: [Standard Non-Tobacco]

The premiums we charge will never be more than the guaranteed maximum premiums shown (See Part 2). The premiums shown do not include any rider premiums.

POLICY YEAR	AGE BEGINNING OF POLICY YEAR	CURRENT ANNUAL PREMIUM	GUARANTEED MAXIMUM ANNUAL PREMIUM
01	35	\$63.25	\$84.25
02	36	\$63.25	\$84.25
03	37	\$63.25	\$84.25
04	38	\$63.25	\$84.25
05	39	\$63.25	\$84.25
06	40	\$78.75	\$123.00
07	41	\$78.75	\$123.00
08	42	\$78.75	\$123.00
09	43	\$78.75	\$123.00
10	44	\$78.75	\$123.00
11	45	\$108.00	\$190.25
12	46	\$108.00	\$190.25
13	47	\$108.00	\$190.25
14	48	\$108.00	\$190.25
15	49	\$108.00	\$190.25
16	50	\$181.25	\$283.00
17	51	\$181.25	\$283.00
18	52	\$181.25	\$283.00
19	53	\$181.25	\$283.00
20	54	\$181.25	\$283.00
21	55	\$293.25	\$477.00
22	56	\$293.25	\$477.00
23	57	\$293.25	\$477.00
24	58	\$293.25	\$477.00
25	59	\$293.25	\$477.00
26	60	\$463.50	\$796.00
27	61	\$463.50	\$796.00
28	62	\$463.50	\$796.00
29	63	\$463.50	\$796.00
30	64	\$463.50	\$796.00
31	65	\$678.75	\$1,302.25
32	66	\$678.75	\$1,302.25
33	67	\$678.75	\$1,302.25
34	68	\$678.75	\$1,302.25
35	69	\$678.75	\$1,302.25
36	70	\$1,077.00	\$2,088.00
37	71	\$1,077.00	\$2,088.00
38	72	\$1,077.00	\$2,088.00
39	73	\$1,077.00	\$2,088.00
40	74	\$1,077.00	\$2,088.00
41	75	\$1,629.00	\$3,465.00
42	76	\$1,629.00	\$3,465.00
43	77	\$1,629.00	\$3,465.00
44	78	\$1,629.00	\$3,465.00
45	79	\$1,629.00	\$3,465.00

Application For [MEMBERS] Individual Term Insurance To Age 80

APPLICANT INFORMATION (Please print in black ink.)

Name _____

First Middle Last

Address _____ City _____ State _____ Zip _____

Home Telephone () [Work Telephone ()]

Best Time to Call: ☐ a.m. ☐ p.m. [E-mail Address: _____]

☐ Male ☐ Female [Height ___ ft. ___ in. Weight ____ lbs] Date of Birth _____ Age _____
Month Day Year

Amount Desired (check one): If no amount is checked, smallest coverage amount is assumed.

[☐ \$15,000 ☐ \$12,000 ☐ \$9,000 ☐ \$6,000 ☐ \$3,000]

☐ Please add \$[25,000] Accidental Death Protection
\$[2.00]/monthly automatic (ages 18-49) \$[2.50]/monthly automatic (ages 50-59)

[Are You a US Citizen? ☐ Yes ☐ No] Social Security # - -

Beneficiary Name _____ Relationship to You _____
(For additional beneficiaries, please include a separate sheet with names and relationships, then date and sign.)

SPOUSE or PARTNER INFORMATION (Please print in black ink, if to be insured.)

Name _____

First Middle Last

Address _____ City _____ State _____ Zip _____

Home Telephone () _____ [Work Telephone () _____] [Cell Phone () _____]

Best Time to Call: ☐ a.m. ☐ p.m. [E-mail Address: _____]

☐ Male ☐ Female [Height ___ ft. ___ in. Weight ____lbs] Date of Birth _____ Age _____
Month Day Year

Amount Desired (check one): If no amount is checked, smallest coverage amount is assumed.

☐ \$15,000 ☐ \$12,000 ☐ \$9,000 ☐ \$6,000 ☐ \$3,000]

☐ Please add \$[25,000] Accidental Death Protection
\$[2.00]/monthly automatic (ages 18-49) \$[2.50]/monthly automatic (ages 50-59) \$[3.00]/monthly automatic (ages 60-69)

[Are You a US Citizen? ☐ Yes ☐ No] Social Security # _____ - _____ - _____

Beneficiary Name _____ Relationship to You _____
(For additional beneficiaries, please include a separate sheet with names and relationships, then date and sign.)

PLEASE ANSWER THESE QUESTIONS: <i>[If yes, please indicate √ the condition(s)]:</i>	APPLICANT	SPOUSE PARTNER
[1.] Has illness or injury caused you to retire, or are you currently unable to work because of injury or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[2.] Have you, within the past 5 years, been treated for or diagnosed by a member of the medical profession as having: <input type="checkbox"/> insulin dependent diabetes; <input type="checkbox"/> stroke; <input type="checkbox"/> paralysis]; <input type="checkbox"/> heart disease or condition (except high blood pressure); <input type="checkbox"/> cancer; <input type="checkbox"/> chronic kidney disease; <input type="checkbox"/> lupus; <input type="checkbox"/> chronic lung condition; <input type="checkbox"/> liver disorder; <input type="checkbox"/> acquired immune deficiency syndrome (AIDS) or AIDS Related Complex (ARC); <input type="checkbox"/> chronic depression; <input type="checkbox"/> mental disorder or disorder of the brain or spinal nerves?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[3.] Have you received counseling or medical treatment for, or been advised by a member of the medical profession to discontinue, the use of alcohol or prescribed or non-prescribed drugs?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

[CONTINUE ON BACK AND SIGN AND DATE]

[EXISTING COVERAGE & REPLACEMENT QUESTIONS:]		APPLICANT	SPOUSE PARTNER
[4.] Do you have any existing life insurance policies or annuity contracts with our company or any other company?		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[5.] Will the coverage applied for replace, discontinue, or change any existing life coverage or annuities in this or any other company? (If yes, please list [below]. Use additional sheet if necessary.)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Insured	Name of Company & Policy Number	Coverage Amount	Coverage Type

AUTOMATIC PAYMENT AUTHORIZATION: [By signing] [below,] I [(the applicant] [shown above)] **authorize** CMFG Life Insurance Company [and the credit union] [below] to [retain my account information and deduct] [monthly] premiums from [my] [credit union] [account] for the life [coverage] applied for on this application. This authorization will remain in effect until revoked by me in writing or by [telephone].

Please check the type of account:

[☐ **Share Draft/Checking Acct** or ☐ **Primary Share Savings Acct**]

[If you do not select an account type, we will deduct premiums from your share draft (checking) account.]

[Deductions will be determined by the policy effective date unless another date is selected.] [Circle the day of the month you prefer for account deductions: **1 5 10 15 20 25 Other Day** _____] [(Note: Allow 2 business days from the above selected date for deductions to occur from your account.) [The first deduction may not be deducted on the day of the month you have selected. We will notify you in writing before the first deduction occurs.)]

AGREEMENT: All my statements and answers are true to the best of my knowledge and belief. This application will be the basis of any insurance issued. I understand that: (1) benefits may be denied during the first 2 years from the effective date if I fail to give true and complete answers in this application, as described in the incontestability provision of the policy; and (2) this insurance becomes effective only if: 1) my application is approved and a policy is issued; 2) the first full premium due is received while I am alive and within 21 days of my policy's effective date; and 3) the answers to questions concerning my insurability are as stated in this application. [Agents are not authorized to determine insurability, void, waive or change any terms of the application, or make a contract for the Company.]

Applicant's Signature

Date Signed

Card Holder's Signature

Date Signed

Spouse or Partner's Signature (if applying)

Date Signed

Agent's Signature

Agent's Printed Name

Date Signed

[Agent Code]

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, and denial of insurance benefits, depending on state law. [State Variations]

CMFG Life Insurance CompanyP.O. Box 61, 2000 Heritage Way
Waverly, IA 50677**Application For [MEMBERS]
Individual Term Insurance To Age 80****APPLICANT COVERAGE:**

Select the amount of Term Coverage (check one):

☐ \$250,000 ☐ \$150,000 ☐ \$50,000]

If no amount is selected, the lowest amount is assumed.

☐ Please add \$[50,000] Accidental Death Protection

[\$4.00]/mo. automatic (ages 18-49) \$[5.00]/mo. automatic (ages 50-59)

[Int Code:1234 CU12345678] [mmdyyy MN1234567890123 1234 X]

APPLICANT INFORMATION:

Name _____

Address _____

City _____ State _____ ZIP _____

[E-mail Address: _____]

Social Security # _____ - _____ - _____

Date of Birth _____ Age _____

() _____

Home Telephone _____ Best Time to Call: ☐ a.m. ☐ p.m.

() _____

Work Telephone _____ Best Time to Call: ☐ a.m. ☐ p.m.

() _____

Cell Phone _____ Best Time to Call: ☐ a.m. ☐ p.m.Are You a US Citizen? ☐ Yes ☐ NoGender: ☐ M ☐ F

Occupation _____

ft. _____ in. _____ lbs. _____

Height _____ Weight _____ State Where Born _____

Beneficiary Name _____ Relationship to You _____

(For additional beneficiaries, please include a separate sheet with names and relationships, then date and sign.)

Your Physician or Clinic (if none, write "none") City _____ State _____

SPOUSE OR PARTNER COVERAGE (If applying):

Select the amount of Term Coverage (check one):

☐ \$250,000 ☐ \$150,000 ☐ \$50,000]

If no amount is selected, the lowest amount is assumed.

☐ Please add \$[50,000] Accidental Death Protection

[\$4.00]/mo. automatic (ages 18-49) \$[5.00]/mo. automatic (ages 50-59)

SPOUSE OR PARTNER INFORMATION:

Name _____

Address _____

City _____ State _____ ZIP _____

[E-mail Address: _____]

Social Security # _____ - _____ - _____

Date of Birth _____ Age _____

() _____

Home Telephone _____ Best Time to Call: ☐ a.m. ☐ p.m.

() _____

Work Telephone _____ Best Time to Call: ☐ a.m. ☐ p.m.

() _____

Cell Phone _____ Best Time to Call: ☐ a.m. ☐ p.m.Are You a US Citizen? ☐ Yes ☐ NoGender: ☐ M ☐ F

Occupation _____

ft. _____ in. _____ lbs. _____

Height _____ Weight _____ State Where Born _____

Beneficiary Name _____ Relationship to You _____

(For additional beneficiaries, please include a separate sheet with names and relationships, then date and sign.)

Your Physician or Clinic (if none, write "none") City _____ State _____

PLEASE ANSWER THESE QUESTIONS: [If yes, please indicate ✓ the condition(s)]:

[1.] Have you, in the past 5 years, had your driver's license suspended or revoked, or pled guilty to or been convicted of 3 or more moving violations?

APPLICANT ☐ Yes ☐ NoSPOUSE PARTNER ☐ Yes ☐ No

[2.] Are you involved in: non-commercial flights as a pilot or crew member, hang gliding, sky/scuba diving, vehicle racing or mountain climbing?

☐ Yes ☐ No☐ Yes ☐ No

[3.] Have you ever: used narcotics, hallucinogens or cocaine except as prescribed by a member of the medical profession; or been advised by a member of the medical profession to discontinue the use of alcohol?

☐ Yes ☐ No☐ Yes ☐ No

[4.] Have you ever had any insurance declined, postponed, altered or offered at a higher than standard premium?

☐ Yes ☐ No☐ Yes ☐ No

[5.] Have you used any form of tobacco, including nicotine substitutes, in the last 12 months?

☐ Yes ☐ No☐ Yes ☐ No

[6.] Have you ever been treated or diagnosed by a member of the medical profession as having:

[a.] ☐ diabetes; ☐ high blood pressure; ☐ cancer; ☐ heart condition; ☐ lupus; ☐ paralysis or stroke; or disorders related to: ☐ intestines; ☐ breathing; ☐ blood; ☐ seizures; ☐ mental or nervous system; ☐ muscles; ☐ liver; or ☐ kidney?☐ Yes ☐ No☐ Yes ☐ No[b.] ☐ Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or tested positive for Human Immunodeficiency Virus (AIDS virus)?☐ Yes ☐ No☐ Yes ☐ No

[7.] During the last 5 years, have you been examined, received treatment or been advised to seek treatment by a member of the medical profession? [(You may omit treatment for minor injuries or illnesses (such as colds) which prevent normal activities for less than 5 days.)]

☐ Yes ☐ No☐ Yes ☐ No

[8.] Are you currently unable to work because of any illness or injury?

☐ Yes ☐ No☐ Yes ☐ No

Give dates and details below for any "Yes answers to questions 1-8 [above]. If more space is needed, attach a signed & dated separate sheet.

Question Number	Name of Person	Details or Reasons	Dates Began	Dates Ended	Details of Treatment or Follow-Up	Name & Address of [Medical Professional], Clinic or Hospital

[EXISTING COVERAGE & REPLACEMENT QUESTIONS:]

	APPLICANT	SPOUSE PARTNER
[9.a.] Do you have any existing life insurance policies or annuity contracts with our company or any other company?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[9.b.] Will the coverage applied for replace, discontinue, or change any existing life coverage or annuities in this or any other company? (If yes, please list [below]. Use additional sheet if necessary.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of Insured	Name of Company & Policy Number	Coverage Amount	Coverage Type

AUTOMATIC PAYMENT AUTHORIZATION: [By signing] [below], I [(the applicant] [shown above)] **authorize** CMFG Life Insurance Company [and the credit union] [below] to [retain my account information and deduct] [monthly] premiums from [my] [credit union] [account] for the life [coverage] applied for on this application. This authorization will remain in effect until revoked by me in writing or by [telephone].

Please check the type of account:

[☐ **Share Draft/Checking Acct** or [☐ **Primary Share Savings Acct]**

[If you do not select an account type, we will deduct premiums from your share draft (checking) account.]

[Deductions will be determined by the policy effective date unless another date is selected.] [Circle the day of the month you prefer for account deductions: **1 5 10 15 20 25 Other Day** _____] [(Note: Allow 2 business days from the above selected date for deductions to occur from your account.] [The first deduction may not be deducted on the day of the month you have selected. We will notify you in writing before the first deduction occurs.)]

AGREEMENT: All my statements and answers are true to the best of my knowledge and belief. This application will be the basis of any insurance issued. I understand that: (1) benefits may be denied during the first 2 years from the effective date if I fail to give true and complete answers in this application, as described in the incontestability provision of the policy; and (2) this insurance becomes effective only if: 1) my application is approved and a policy issued; 2) my first full premium due is received while I am alive and within 21 days of my policy's effective date; and 3) the answers to questions concerning my insurability are as stated in this application.. [Agents are not authorized to determine insurability, void, waive or change any terms of the application, or make a contract for the Company.]

I authorize any health care providers, pharmacy benefit manager or other pharmaceutical firm, insurance companies, MIB, Inc. (MIB), consumer reporting agency, the Department of Motor Vehicles, financial institution, or employer having information about my physical or mental condition, prescription drug records, financial status, employment status, or other relevant information about me, to give all information (except psychiatric treatment notes) to CMFG Life Insurance Company ("Company") or its reinsurers to determine eligibility for insurance or benefits. Information obtained will be released only to reinsurers, MIB, persons performing business duties as delegated or contracted for by the Company related to my application and subsequent insurance-related functions, as permitted or required by law, or as I further authorize. Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I agree this authorization is valid for 24 months, a copy is as valid as the original, and I or my authorized representative can receive a copy upon request. For purposes of collecting information in connection with a claim for benefits, this Authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by written request to the Company; (2) revocation of this authorization will not affect any prior action taken by the Company in reliance upon this authorization; and (3) failure to sign, or revocation of this authorization may impair the Company's ability to evaluate claims or process applications and may be a basis for denying this application or a claim for benefits. The Notice to Applicant has been received by me.

Applicant's Signature _____	Date Signed _____	Card Holder's Signature _____	Date Signed _____
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Spouse or Partner's Signature (if applying) _____	Date Signed _____
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Agent's Signature _____	Agent's Printed Name _____	Date Signed _____	[Agent Code] _____
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Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, and denial of insurance benefits, depending on state law. [State Variations]

ACCIDENTAL DEATH BENEFIT RIDER

This rider is a part of the policy to which it is attached. The provisions of your policy apply to this rider unless they conflict with the rider. If there is a conflict, the rider provision will apply.

RIDER SCHEDULE

Insured: [John Doe]		ADB Amount: [\$50,000]			
Rider Effective Date: [June 1, 2012]		Rider Expiration Date: [June 1, 2057]			
Rider Is Attached To Policy Number: [123456789]		Issue Age and Gender: [35 Male]			
Rider Premiums:	\$[4.00]	\$[4.50]	\$[12.50]	\$[24.50]	\$[47.50]
	Monthly Automatic Payment	Monthly Direct Bill	Quarterly Direct Bill	Semi-Annual Direct Bill	Annual Direct Bill

1.1 What is the benefit provided by this rider?

We will pay the accidental death benefit ("ADB") amount shown on the rider schedule if the following conditions are met:

- 1.) Death is the direct result of accidental bodily injury, independent of disease or bodily or mental illness or infirmity or any other cause;
- 2.) The accidental bodily injury was sustained while the policy and rider are in force;
- 3.) Death occurs within 180 days of the injury;
- 4.) Death occurs on or after the effective date of coverage under this rider and while this rider is in force; and
- 5.) We receive satisfactory proof of accidental death and proof of the claimant's interest in the proceeds.

The accidental death benefit amount will be payable to the beneficiary on file at our administrative office when we receive satisfactory proof of the insured's death due to accidental bodily injury.

1.2 Are there any exclusions to payment of this benefit?

We will not pay any accidental death benefit if the insured's death is the result of any of the following causes:

- 1.) Death caused or contributed to by any attempt at suicide, or intentionally self-inflicted injuries, while sane or insane;
- 2.) Death caused or contributed to by travel in or descent from an aircraft, if the insured acted in a capacity other than as a passenger;
- 3.) Death as a result of war or act of war while serving in the military, or in any civilian non-combatant unit serving with the military;
- 4.) Death caused or contributed to by active participation in a riot, insurrection or terrorist activity;
- 5.) Death caused or materially contributed to by voluntary intake or use by any means of:
 - a.) any drug, unless prescribed or administered by a physician and taken in accordance with the physician's instructions; or
 - b.) poison, gas or fumes, unless a direct result of an occupational accident;
- 6.) Death caused or contributed to by intoxication as defined by the jurisdiction where the accident occurred;
- 7.) Death caused or contributed to by committing or attempting to commit a felony;
- 8.) Death caused or contributed to by:
 - a.) aeronautics (hang-gliding, skydiving, parachuting, ultralight, soaring, ballooning and parasailing);
 - b.) scuba diving;
 - c.) riding or driving an air, land or water vehicle in a race, speed or endurance contest;
 - d.) bungee jumping; or
 - e.) rock or mountain climbing;

- 9.) Death caused or materially contributed to by participation in an illegal occupation or activity; or
- 10.) Death caused or contributed to by disease or infirmity of mind or body, or medical or surgical treatment for such disease or infirmity.

“Military” means the military, naval or air forces of any country, combination of countries or international organization.

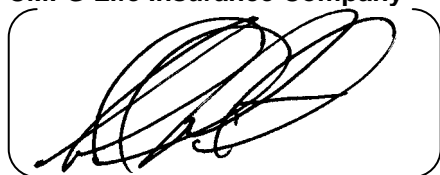
“War” includes, but is not limited to, declared war, and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization.

“Act of war” means any act peculiar to military, naval or air operations in time of war.

- | | |
|---|--|
| 1.3 When does this rider become incontestable? | This rider is incontestable after it has been in force during the insured's lifetime for a period of two years from the rider effective date except for fraud. |
| 1.4 Does this rider have any cash or loan value? | This rider does not have any cash or loan value. |
| 1.5 When will this rider terminate? | <p>This rider will terminate on the earlier of:</p> <ul style="list-style-type: none">1.) The date of death of the insured;2.) The date the policy lapses or is terminated;3.) The date of non-payment of the Rider Premium, subject to the policy grace period;4.) The date the policy is continued as extended term insurance or reduced paid-up insurance under a nonforfeiture option;5.) The Rider Expiration Date shown on the Rider Schedule for this rider; or6.) The date you choose to end this rider. You may end it by written request. |

An otherwise valid claim for an accidental bodily injury that was sustained while this rider was in force will not be denied due to termination of this rider.

CMFG Life Insurance Company



President



Rider Application Accidental Death Protection

POLICY NUMBER: _____

APPLICANT INFORMATION (Please print in black ink.)

Name _____
First Middle Last

Address _____ City _____ State _____ Zip _____

[E-mail Address: _____] Social Security # _____ - _____ - _____

☐ Male ☐ Female Date of Birth _____ Age _____
Month Day Year

Home Telephone () _____ [Work Telephone () _____] [Cell Phone () _____]

Best Time to Call: ☐ a.m. ☐ p.m.

Amount of Accidental Death Protection Desired: \$ _____

AGREEMENT: All my statements and answers are true and complete to the best of my knowledge and belief. I understand that this application is the basis for the Accidental Death Protection Rider (Rider) issued. I understand that the Rider will become effective only if: (1) my application is approved and a Rider is issued; and (2) the first full Rider premium due is received while I am alive and within 21 days of my Rider effective date.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, and denial of insurance benefits, depending on state law. Agents are not authorized to determine insurability, void, waive or change any terms of the application, or make a contract for the Company. [State Variation Fraud Language]

Applicant's Signature Date Signed

Agent's Signature Agent's Printed Name Date Signed [Agent Code]

APPLICATION CHANGE ENDORSEMENT

Name of Insured [John Doe]	Policy Number [123456789]	Effective Date of Change [SEE POLICY EFFECTIVE DATE]
-------------------------------	------------------------------	---

It is hereby understood and agreed that the Policy to which this Endorsement is attached is amended as follows:

Dictation Area
See Memorandum of Variable Material

STATEMENT OF HEALTH

I, the undersigned:


1. Declare that to the best of my knowledge and belief that the answers to questions concerning [my] insurability are as stated in the application and that [I have] not consulted a member of the medical profession since the date of application for coverage under the above-referenced Policy.
2. Declare that since the date of application for coverage under the above-referenced Policy, [I have] not made an application for insurance which has been declined, postponed or modified.

If there are exceptions to the above, give complete information below.

I declare that all statements and answers made above are full, true and complete to the best of my knowledge and belief. I agree that this information will be a part of the original application and any policy issued on the basis of the application.

<input checked="" type="checkbox"/> _____ Signature of Insured [Insured Name]	_____ Date
<input checked="" type="checkbox"/> _____ Signature of Owner [Owner Name]	_____ Date
<input checked="" type="checkbox"/> _____ Signature of Parent or Guardian of Insured [Insured Name]	_____ Date

CMFG Life Insurance Company


President

**PLEASE ATTACH THIS ENDORSEMENT
TO YOUR POLICY**



CMFG Life Insurance Company

2000 Heritage Way
Waverly, IA 50677-0061
Phone: 800.779.5433

[John Doe]
[1234 Main Street]
[Anywhere, State 98765]

Amendment to Application

Insured's name: [John Doe]

[Order/Policy] Number: [123456789]

We have received your request [to convert your term policy to [Product Description]] [for [Product Description]]. This form asks for information that is either unclear or incomplete from the Application. Please review the sections that follow and provide the details requested. It is important to verify that all information is accurate. **[Please complete, sign and date this document. Also, complete, sign and date the enclosed Endorsement. Return both forms to us in the envelope provided by [Required Due Date]], [Please return this document, signed and dated, in the envelope provided by [Required DueDate],] [so we can complete your request. If we do not hear from you by this date, we will need to close your file.] [so we can complete our records.]**

Thank you for your time and prompt attention to this matter. If you have questions, please call [1-800-779-5433], [4831234].

ALIEN REGISTRATION CARD

After reviewing the application, we note that you are not currently a U.S. citizen. Therefore, it will be necessary for us to receive a photocopy of your Alien Registration card.

PLEASE RETURN THE PHOTOCOPY OF YOUR ALIEN REGISTRATION CARD WITH THIS FORM.

AVIATION QUESTIONNAIRE

We need to clarify your participation in aviation activities. Please complete the enclosed questionnaire and return it to our office in the envelope provided.

UNITED STATES CITIZENSHIP

[State/Country where you were born? _____]

Are you a United States citizen? Yes ____ No ____

If you are **not** a United States citizen, it is necessary for us to receive a photocopy of your Alien Registration Card.

PLEASE RETURN THE PHOTOCOPY OF YOUR ALIEN REGISTRATION CARD WITH THIS FORM.

[Order Number] [Please look on the back of this form to see if more information is needed.]

CREDIT UNION INFORMATION

Credit Union Name: _____

Address (Street, City, State, Zip Code): _____

HAZARDOUS SPORTS QUESTIONNAIRE

We need to clarify your participation in hazardous sports. Please complete the enclosed questionnaire and return it to our office in the envelope provided.

HEIGHT

The height of [Insured's Name] is: _____

MISSING INFORMATION

There was information missing from the application. Please refer to the enclosed endorsement to complete this information.

OCCUPATION

The occupation of [Insured's Name] is: _____

SOCIAL SECURITY NUMBER

[Insured's Name]

____ - ____ - _____

CHILDREN'S INSURANCE RIDER

Please provide the missing details for the individuals covered under this rider below.

[Child's Name: First _____ Last _____]

[Date of Birth: ______]

[Gender: __male __female]

[Amount of Coverage (please circle the amount you want): [\$5,000 \$10,000]]

WEIGHT

The weight of [Insured's Name] is: _____

[Order Number] [Please look on the back of this form to see if more information is needed.]

TELEPHONE NUMBER

Please provide a telephone number where we can contact you and the time that is most convenient.

Home Telephone (including area code): _____ - _____ - _____

Best Time to Call: _____

[Work Telephone (including area code): _____ - _____ - _____]

[Best Time to Call: _____]

[Cell Telephone (including area code): _____ - _____ - _____]

[Best Time to Call: _____]

ADDRESS CHANGE

If your name, address, or phone number has changed, please provide the correct information below:

Name: _____

Mailing Address: _____

City, State, Zip: _____

Phone Number (Including area code): _____ - _____ - _____

COVERAGE AMOUNT

The amount of insurance was not marked on your application. (See the enclosed copy, which is included for your information. Do not return the enclosed copy of the application.)

Please indicate the coverage amount you wish to apply for: \$_____

DATE OF BIRTH

Month ____ Day ____ Year ____

GENDER

Male ____ Female ____

NAME VERIFICATION

The name provided is incomplete or unclear. Please print this information below.

Insured

First Name: _____ Middle Name: _____ Last Name: _____

[Order Number] [Please look on the back of this form to see if more information is needed.]

AUTOMATIC PAYMENT AUTHORIZATION

Information on the financial institution you want us to automatically deduct your premiums from is needed. Please choose from either [Checking Name] or [Savings Name].

[Checking Name]

Account Number: [Account Number or Blank Line]

Please include a voided check - *Note: This is needed to establish this payment plan*

[Savings Name]

[Complete] Financial Institution Name: [Financial Institution Name or blank line]

Financial Institution Phone Number (including area code): _____

Financial Institution Address: [Financial Institution Address or blank line]

(street, city, state, zip) [Financial Institution Address or blank line]

[Savings Name] Account Number: [Account Number or Blank Line]

Please indicate the day (1-31) of the month you want the premium drawn from your account: _____

Check how often you want premiums drawn from your account:

____ Monthly ____ Quarterly ____ Semi-annually ____ Annually

FINANCIAL ACCOUNT OWNER SIGNATURE

I authorize CMFG Life Insurance Company and the financial institution named here to retain my account information and initiate deductions or credits to my account either by electronic funds transfer or paper draft. This authorization will remain in effect until revoked by me in writing. Deductions will be determined by the policy due date unless another date is selected.

Accountholder's Signature (if different than insured): _____

Date Signed: _____

[Order Number] [Please look on the back of this form to see if more information is needed.]

AUTOMATIC PAYMENT AUTHORIZATION

You requested to have payments taken from your [Account Name] account. Your financial institution only allows automatic payments from your [Account Name] account. Please provide the details requested below so payments can be deducted from your [Account Name] account.

[Checking Name]

Account Number: [Account Number or Blank Line]

Please include a voided check - *Note: This is needed to establish this payment plan*

[Savings Name]

[Complete] Financial Institution Name: [Financial Institution Name or blank line]

Financial Institution Phone Number (including area code): _____

Financial Institution Address: [Financial Institution Address or blank line]

(street, city, state, zip) [Financial Institution Address or blank line]

[Savings Name] Account Number: [Account Number or Blank Line]

Please indicate the day (1-31) of the month you want the premium drawn from your account: _____

Check how often you want premiums drawn from your account:

____ Monthly ____ Quarterly ____ Semi-annually ____ Annually

FINANCIAL ACCOUNT OWNER SIGNATURE

I authorize CMFG Life Insurance Company and the financial institution named here to retain my account information and initiate deductions or credits to my account either by electronic funds transfer or paper draft. This authorization will remain in effect until revoked by me in writing. Deductions will be determined by the policy due date unless another date is selected.

Accountholder's Signature (if different than insured): _____

Date Signed: _____

[Order Number] [Please look on the back of this form to see if more information is needed.]

AUTOMATIC PAYMENT AUTHORIZATION

Information on the financial institution you want us to automatically deduct your premiums from is needed.

[Savings Name]

[Complete] Financial Institution Name: [Financial Institution Name or blank line]

Financial Institution Phone Number (including area code): _____

Financial Institution Address: [Financial Institution Address or blank line]

(street, city, state, zip) [Financial Institution Address or blank line]

[Savings Name] Account Number: [Account Number, or Blank Line]

[Checking Name]

[Complete] Financial Institution Name: [Financial Institution Name or blank line]

Account Number: [Account Number or Blank Line]

Please include a voided check - *Note: This is needed to establish this payment plan.*

Please indicate the day (1-31) of the month you want the premium drawn from your account: _____

Check how often you want premiums drawn from your account:

____ Monthly ____ Quarterly ____ Semi-annually ____ Annually

FINANCIAL ACCOUNT OWNER SIGNATURE

I authorize CMFG Life Insurance Company and the financial institution named here to retain my account information and initiate deductions or credits to my account either by electronic funds transfer or paper draft. This authorization will remain in effect until revoked by me in writing. Deductions will be determined by the policy due date unless another date is selected.

Accountholder's Signature (if different than insured): _____

Date Signed: _____

[Order Number] [Please look on the back of this form to see if more information is needed.]

AUTOMATIC PAYMENT AUTHORIZATION

Thank you for providing your account information. This authorization needs to be signed before payments can be taken from your account.

[Checking Name]/[Savings Name]

[Complete] Financial Institution Name: [Financial Institution Name or blank line]

[Account Name] Account Number: [Account Number or blank line]

Please indicate the day (1-31) of the month you want the premium drawn from your account: _____

Check how often you want premiums drawn from your account:

____ Monthly ____ Quarterly ____ Semi-annually ____ Annually

FINANCIAL ACCOUNT OWNER SIGNATURE

I authorize CMFG Life Insurance Company and the financial institution named here to retain my account information and initiate deductions or credits to my account either by electronic funds transfer or paper draft. This authorization will remain in effect until revoked by me in writing. Deductions will be determined by the policy due date unless another date is selected.

Accountholder's Signature (if different than insured): _____

Date Signed: _____

SIGNATURE REQUIRED

I declare that all statements and answers made above are full, true and complete to the best of my knowledge and belief. I agree that this information will be a part of the original application and any policy issued on the basis of the application.

[_____] _____
[DATE SIGNATURE OF [Insured Name]]

[_____] _____
[DATE SIGNATURE OF [Owner Name]]

[_____] _____
[DATE SIGNATURE OF PARENT OR GUARDIAN OF [Insured Name]]

[Order Number] [Please look on the back of this form to see if more information is needed.]

SERFF Tracking #:	CUNA-128479621	State Tracking #:		Company Tracking #:	A10A-037-2012(AR) & A10A-036-2012(AR), E...
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State:	Arkansas	Filing Company:	CMFG Life Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	CMFG 2012 UT80/UT80EZ		
Project Name/Number:	CMFG 2012 UT80/UT80EZ /		

Rate Information

Rate data applies to filing.

Filing Method:	SERFF
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
CMFG Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

State:	Arkansas	Filing Company:	CMFG Life Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	CMFG 2012 UT80/UT80EZ		
Project Name/Number:	CMFG 2012 UT80/UT80EZ /		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action*	Rate Action Information	Attachments
1		Rate Sheet	A10a-037-2012(AR)	New		A10a-037-2012 - UT80 Premium Rates.pdf
2		Rate Sheet	A10a-036-2012(AR)	New		A10a-036-2012 - UT80EZ Premium Rates.pdf

Underwritten Term to Age 80 - Simplified Underwritten (UT80)**Base Individual Policy Form Number: A10a-037-2012****Annual Premiums Per \$1,000 of Coverage****Guaranteed Maximum Premiums**

Attained Age	Gender and Underwriting Class			
	MNT	MT	FNT	FT
18-24	2.76	3.76	1.98	2.58
25-29	2.77	4.78	2.23	2.84
30-34	2.79	5.02	2.55	3.04
35-39	3.37	6.27	3.06	4.46
40-44	4.92	9.53	4.15	6.23
45-49	7.61	14.85	6.43	9.99
50-54	11.32	21.91	10.74	17.30
55-59	19.08	35.74	17.51	27.81
60-64	31.84	56.40	26.61	41.34
65-69	52.09	85.54	39.97	59.97
70-74	83.52	124.52	62.13	89.75
75-79	138.60	190.25	98.46	133.83

Current Premiums Band 1 \$25,000 - \$49,999

Attained Age	Gender and Underwriting Class			
	MNT	MT	FNT	FT
18-24	N/A	N/A	N/A	N/A
25-29	2.31	3.38	1.90	2.46
30-34	2.41	3.44	2.03	2.57
35-39	2.53	3.88	2.16	3.07
40-44	3.15	4.98	2.58	4.48
45-49	4.32	8.01	3.49	5.66
50-54	7.25	12.04	4.48	7.70
55-59	11.73	17.50	6.18	9.72
60-64	18.54	27.15	8.94	14.65
65-69	27.15	42.73	15.43	21.75
70-74	43.08	63.24	25.48	36.50
75-79	65.16	95.62	40.28	63.50

Current Premiums Band 2 \$50,000 - \$199,999

Attained Age	Gender and Underwriting Class			
	MNT	MT	FNT	FT
18-24	1.54	2.25	1.19	1.54
25-29	1.54	2.25	1.19	1.54
30-34	1.66	2.37	1.31	1.66
35-39	1.78	2.73	1.42	2.02
40-44	2.25	3.56	1.78	3.09
45-49	3.20	5.93	2.49	4.04
50-54	5.58	9.26	3.32	5.70
55-59	9.38	14.00	4.75	7.48
60-64	14.83	21.72	6.88	11.27
65-69	21.72	34.18	11.87	16.73
70-74	34.89	55.65	20.13	29.20
75-79	55.39	87.97	33.03	53.98

Current Premiums Band 3 \$200,000 - \$250,000

Attained Age	Gender and Underwriting Class			
	MNT	MT	FNT	FT
18-24	1.39	2.14	1.07	1.46
25-29	1.39	2.14	1.07	1.46
30-34	1.49	2.25	1.18	1.58
35-39	1.61	2.59	1.28	1.92
40-44	2.03	3.38	1.60	2.94
45-49	2.88	5.63	2.24	3.84
50-54	5.02	8.80	2.99	5.42
55-59	8.44	13.30	4.28	7.11
60-64	13.35	20.63	6.19	10.71
65-69	19.55	32.47	10.68	15.89
70-74	31.40	52.87	18.12	27.74
75-79	49.85	83.57	29.73	51.28

Ages 70 – 79 are Renewal Only

Policy Fee: None

Underwritten Term to Age 80 - Simple Issue (UT80EZ)
Base Individual Policy Form Number: A10a-036-2012

Attained Age	Current Per \$1,000 Annual Premiums		Attained Age	Guaranteed Maximum Per \$1,000 Annual Premiums	
	Male	Female		Male	Female
30-34	6.70	4.90	30-34	7.44	4.95
35-39	6.86	5.04	35-39	9.02	7.00
40-44	8.89	6.53	40-44	13.37	9.54
45-49	11.79	8.45	45-49	20.69	14.85
50-54	15.12	11.05	50-54	30.61	24.72
55-59	21.74	13.93	55-59	50.92	40.04
60-64	30.15	18.67	60-64	83.53	60.41
65-69	41.68	25.47	65-69	134.46	89.68
70-74	75.61	42.73	70-74	210.57	137.80
75-79	144.46	71.26	75-79	342.99	215.65

Ages 70 – 79 are Renewal Only

Policy Fee: None

SERFF Tracking #:	CUNA-128479621	State Tracking #:		Company Tracking #:	A10A-037-2012(AR) & A10A-036-2012(AR), E...
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State:	Arkansas	Filing Company:	CMFG Life Insurance Company
TOI/Sub-TOI:	L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium		
Product Name:	CMFG 2012 UT80/UT80EZ		
Project Name/Number:	CMFG 2012 UT80/UT80EZ /		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
UT80 - UT80EZ Certification of Readability AR.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	Please find application on form scchedule		

		Item Status:	Status Date:
Satisfied - Item:	Authorization		
Comments:			
Attachment(s):			
Authorization letter _CMFG version_.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
SoV A10a-036-2012 et al.pdf			
AMEND-2012 SoV(REV).pdf			
ENDORSE-2012 SoV(REV).pdf			

		Item Status:	Status Date:
Satisfied - Item:	987AR 0212		
Comments:			
Attachment(s):			

SERFF Tracking #:	CUNA-128479621	State Tracking #:		Company Tracking #:	A10A-037-2012(AR) & A10A-036-2012(AR), E...
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State: Arkansas
TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: CMFG 2012 UT80/UT80EZ
Project Name/Number: CMFG 2012 UT80/UT80EZ /


Filing Company: CMFG Life Insurance Company

987AR 0212.pdf

		Item Status:	Status Date:
Satisfied - Item:	AR Cert of Comp with Rule 19 & 49		
Comments:			
Attachment(s):			
AR Cert of Comp with Rule 19 & 49.pdf			

CERTIFICATION OF READABILITY

INSURANCE DEPT. USE ONLY

STATE Arkansas		PROPOSED EFFECTIVE DATE Upon Approval by the Department.		<input type="checkbox"/> APPROVED <input type="checkbox"/> FILE & USE <input type="checkbox"/> DISAPPROVED <input type="checkbox"/> WITHDRAWN		FILE I.D. DATE DATE DATE DATE	ANALYST INITIALS INITIALS INITIALS INITIALS
NAME AND ADDRESS OF FILER CMFG Life Insurance Company							
CONTACT PERSON Nancy French				CONTACT TELEPHONE 513.984.6050			
The Flesch Score(s) for the form(s) listed below is (are) as stated opposite each listed form. (Alternate approved methods, if any, are identified.) Typeface styles and minimum type point sizes are identified and stated opposite each listed form.							
FORM NO.	FORM TITLE/DESCRIPTION	LINE OF INS.	FLESCH SCORE	ALT. SCORE CALCULATION	TYPEFACE STYLE	MIN. TYPE POINT SIZE	
A10a-036-2012(AR)	Individual Term Life Policy To Age 80	56					
A10a-037-2012(AR)	Individual Term Life Policy To Age 80	56					
A10f-036(J)-2012	Individual Term Life Application	61					
A10f-037(J)-2012	Individual Term Life Application	57					
A10ad-ADB-2012	Individual Accidental Death Benefit Rider	54					
A10fd-ADB-2012	Individual Accidental Death Benefit Rider Application	63					
ENDORSE-2012	Individual Application Endorsement	60					
The insurance company certifies that the above named forms filed by the company, or on its behalf, meet the minimum standards of readability required by the laws of this state.							
SIGNED 			COMPANY CMFG Life Insurance Company				
TITLE (COMPANY OFFICER) SVP, Chief Ethics and Compliance Officer				DATE 7-23-2012			



CMFG Life Insurance Company

Home Office:
2000 Heritage Way
Waverly, IA 60577
Telephone: 800.798.5433

May 14, 2012

Re: CMFG Life Insurance Company
NAIC #: 62626-0306 **FEIN #: 39-0230590**
Equip for Life Filing
Company Authorization to Draft and File Policy Forms

To Whom It May Concern:

The undersigned hereby grants **Compliance Research Services, LLC**, whose main office is located at 10921 Reed Hartman Highway, Suite 332, Cincinnati, Ohio 45242, authority to act on our behalf regarding drafting of policy language and state insurance department filings of our Equip for Life product filings.

This authorization is valid effective from the date noted above, for the duration of the filing project.

If additional assistance or verification regarding this authorization is required, please contact Kari Hamrick, Senior Manager, Ethics & Compliance, at CMFG Life Insurance Company. She can be reached by phone at 608.665.8326 or 800.356.2644, Ext. 8326.

IN WITNESS THEREOF, the Company has caused this authorization to be in effect by the signature of its Senior Vice President, Chief Ethics & Compliance Officer.

A handwritten signature in black ink, appearing to read "S. W. Koslow", written over a horizontal line.

Signature

Stephen W. Koslow
SVP, Chief Ethics & Compliance Officer

Cc: Kari Hamrick

CMFG Life Insurance Company - Memorandum of Variable Material - June 29, 2012
Base Forms: A10a-036-2012, A10a-037-2012, A10f-036(J)-2012, A10f-037(J)-2012, A10ad-ADB-2012 & A10fd-ADB-2012

Form	Variable	Explanation
A10a-036-2012 A10a-037-2012	Company Logo	Allows for future changes to our logo. Logo may also be removed.
	Home Office Address & Telephone Number	Allows for future changes to the home office address and telephone number.
	John Doe Information on Policy Schedule	Bracketing shows variability for each individual insured. Brackets around the billing options allow the addition of billing options in the future if the company should choose to make them available. Brackets also allow for the removal of one or more billing option if the company should choose to do so.
	President and Secretary Signatures on Policy Face Page	Allows for future changes. If the Company's President or Secretary should change, the new officer's signature will be reflected for new issues of the policy.
	Premium Table	Bracketing shows variability for each individual insured. The premiums that are applicable to each individual insured are based on the individual's age, gender & tobacco status. The values shown are for filing purposes only, and may be revised to match the actuarial administrative system generated premiums, if any differences are discovered prior to the form being issued.
	Premium Class on Policy Schedule & Premium Table	Bracketing shows variability for each individual insured. <ul style="list-style-type: none"> Form A10a-036-2012 – Currently the only choice is "Standard". Form A10a-037-2012 - Currently the choices are: "Standard Tobacco", "Standard Non-Tobacco" "Rated Tobacco" & "Rated Non-Tobacco" In the event other premium classes are added, we will file a revised statement of variables prior to use.
Form	Variable	Explanation
A10ad-ADB-2012	Company Logo	Allows for future changes to our logo. Logo may also be removed.
	John Doe Information on Rider Schedule	Bracketing shows variability for each individual insured. Brackets around the billing options allow the addition of billing options in the future if the company should choose to make them available. Brackets also allow for the removal of one or more billing option if the company should choose to do so.
	President's Signature	Allows for future changes. If the Company's President should change, the new officer's signature will be reflected for new issues of the policy.
Form	Variable	Explanation
A10f-036(J)-2012 A10f-037(J)-2012 A10fd-ADB-2012 (See the last page for additional variables that apply to Form A10f-036(J)-2012 only.)	General Formatting	The application content will not be changed, except as provided in this document. However, the application may be reformatted, sections rearranged, and the ink colors, shading, highlighting and font types may be revised for direct mail marketing purposes.
	Home Office Address (& Telephone Number for form A10fd-ADB-2012)	Allows for future changes to the home office address and telephone number.
	Applicant & Spouse or Partner Name & Address Lines	This information is either written in by the applicant or a prepared mailing label is placed in this area.
	Email Address	Will either appear, or will be removed in its entirety.
	Phone Numbers	Any combination of Cell Phone, Primary Phone and/or Work Phone may be printed.
	State Variation Fraud Language	The field "State Variation Fraud Language" or "State Variations" will ONLY be used to add state language that may required by a particular state. It will not be used to alter the existing language approved and applicable to your state.
Form	Variable	Explanation
A10f-036(J)-2012 A10f-037(J)-2012	Marketing Name	"MEMBERS" is bracketed and may be removed or revised to be consistent with a new marketing name.
	Coverage Amount	Will either be a selection of coverage amounts (\$1,000 - \$25,000 for form A10f-036(J)-2012; and \$25,000 to \$250,000 for form A10f-037(J)-2012), or a blank line will appear to write in the coverage amount desired.
	Accidental Death Protection	The offer for Accidental Death Protection may or may not appear. The dollar amount will either be a specific dollar amount (\$25,000 to \$200,000) or a blank like will appear to write in the coverage amount desired.
	Internal Code	An internal code will print solely for administrative purposes.
	Instructional Text Preceding Questions	We may delete the bracketed information "If yes, please indicate √ the condition(s)" or replace it with similar types of instructional language such as: "If yes, please circle the condition(s)", "If yes, please check √ the condition(s)", or "If yes, please check √ below."

Form	Variable	Explanation
Continued for: A10f-036(J)-2012 A10f-037(J)-2012	Health Questions	<ul style="list-style-type: none"> • Check Boxes: The bracketed check boxes which precede the health conditions will appear only if we instruct the applicant to indicate or check the condition(s) for which they are answering “Yes”. The conditions that appear with checkboxes may also be reordered. None of the conditions will be deleted or revised in any other manner. • The questions may or may not be numbered. If numbered, Question #6 on form ICC12-A10f-037(J) may also be further divided into “a”, “b”, “c”, “d”, etc. • Question #7 on form ICC12-A10f-037(J) – Bracketed info may be deleted, moved to the “Details for Yes Questions area” or revised for clarity.
	Existing Coverage & Replacement Questions.	<ul style="list-style-type: none"> • Entire heading will not print if both questions are relocated to be part of the health questions section. If the questions are separated, the heading may be altered. For example: “Existing Coverage Question” or “Replacement Question” if the questions are separated. • The questions may or may not be numbered. • Existing insurance question will always print if the application is completed by an agent via telephone. The question may be deleted for direct mail applications.
	Details to Yes Questions Box	<ul style="list-style-type: none"> • “above” may be deleted or replaced with “on the reverse side”, or similar instructional location wording. • “Medical Professional” may be replaced with “Physician”.
	1. Automatic Billing Option Payment Language <i>The language below that is blue and bracketed corresponds to the Explanations to the RIGHT.</i> <u>[Section Title]</u> <u>[By signing]</u> <u>[Location of Signature]</u> I <u>[The Applicant]</u> <u>[Applicant Name Location]</u> authorize CMFG Life Insurance Company <u>[and the]</u> <u>[Financial Institution]</u> <u>[Location of Financial Institution Named]</u> to <u>[Action]</u> <u>[Frequency of Deductions]</u> <u>[Premiums From]</u> <u>[Pronoun]</u> <u>[Financial Institution Type]</u> , <u>[Account Selection Wording]</u> <u>[Account Type]</u> for the life <u>[Coverage]</u> applied for on this application. This authorization will remain in effect until revoked by me in writing or by <u>[Telephone]</u> . <u>[Payment Default Language]</u> <u>[Deduction Date Language]</u> <u>[Payment Date Selection]</u> <u>[Voided Check Language]</u> <u>[Legal Disclosure Language]</u>	<p>We may choose to bold, underline or capitalize certain words for emphasis and clarity in this billing language. Also, the billing language may be written either in the First Person Point of View (I) or the Second Person Point of View (you) for readability and clarity.</p> <p><u>Section Title:</u> Any combination of the following words – bracketed words may be removed entirely or used as other options:</p> <p>[LOWEST COST OPTION] [AUTOMATIC] [PAYMENT] [PAYMENTS] [AUTHORIZATION] [INFORMATION]: [(select one)]</p> <p>The phrase “<u>By signing</u>,” will print or will be deleted entirely.</p> <p><u>Location of Signature:</u> Either no location will print or language will be included explaining where the applicant should sign. For example, words/phrases such as [here] [below] [above] [to the right] or [to the left], [on reverse side] etc. may be used.</p> <p><u>The Applicant:</u> After the word “I” explanatory words such as [the applicant] or [the applicant shown] may be included. If they are deleted the copy reads “I authorize CMFG Life Insurance Company”</p> <p><u>Applicant Name Location:</u> Will either be blank, or language indicating location of where the applicant’s name is located will print after the word [shown]. These “location” words such as: [on the reverse side] [above] [below] [reverse side] etc. may be used.</p> <p><u>Financial Institution:</u> Will either be blank or may print [financial institution named] [credit union] [the actual credit union name] [bank] [bank name] or [Savings & Loan] [Savings & Loan name] or [Other Financial Institution] [Other Financial Institution named]. The Financial Institution Name may or may not be preceded with the words <u>[and the]</u>.</p> <p><u>Location of Financial Institution Named:</u> Will either be blank, or language indicating location of where the financial institution’s name is located will print such as: [on the reverse side] [above] [here/below] [here] [below] [reverse side] etc. may be used.</p> <p><u>Action:</u> Will either be blank, or one or a combination of the following words or phrases will print: [retain my account information] [and deduct] [and to deduct] [from my] [retain my account information and make automatic monthly premium deductions from my] [deduct premiums from the account I have designated below] [deduct] [deduct premiums]</p>

Form	Variable	Explanation
Continued for: A10f-036(J)-2012 A10f-037(J)-2012		<p>Frequency of Deductions/Bill Mode: Will be blank or one of the following bracketed words may be used: [monthly] [each month] [bi-monthly] [quarterly] [each quarter] [semi-annually] [semi-annual] [annually] [yearly] [once a year]</p> <p>Premiums From: Will either be blank or will be one of the following: [premiums each month from] [premiums from] [premiums] or [from]</p> <p>Pronoun: Will either be blank or the appropriate pronoun(s) or possessives will be used here, depending on need such as [my] [the] [I] [I have] or [I've]</p> <p>Financial Institution Type: Will either be blank or will print one of the following: [credit union]. [credit union name] [bank] [bank name] [Savings & Loan] [Savings & Loan name] or [Other] [Financial Institution]</p> <p>Account Selection Wording: Will either be blank or phrases will be used here such as; [the account I selected] [the account I've selected] or [the account I designated] or [the account I've designated]</p> <p>Account Type: Any combination of the following bracketed words/sections may or may not be included depending on the offer::</p> <ol style="list-style-type: none"> [credit union] [specific credit union name] [my financial institution] [share] [draft] [primary] [checking] [savings] [share draft (checking)] [share draft/checking account] [checking/savings] [OR] [or] [account] [acct.] [(provide account number)] [# _____] [Routing # _____] [Routing # _____] [(must be 9 digits)] [(please write it in)] [as provided here or over the phone] [the account I have designated below] [designated] [below] [indicated] [shown] [on the VOID check] [on the voided check] [Pay each [Frequency of Deductions/Bill Mode, referenced above] from my account listed below or] [(Option "A")] [(Option "B")] [(Option "C")] [from my credit card] [My checking account at the financial institution indicated on the VOID check [below] [above] [attached].] [My credit union] [account type]. [credit union] [primary] Share [Draft] [checking] [savings] [account] [Acct.] [# _____] [suffix #] [or suffix # _____] [(please write it in)] [as provided here or over the phone, designated below] [(if suffix is not indicated, suffix #90 for your Primary Share Draft account is assumed)] [Pay] [Deduct] [Bill] [each] [Frequency of Deductions/Bill Mode, referenced above] from my [Account Type, referenced above] account. Routing # _____ (must be 9 digits). Acct # _____ Day of the Month for Deductions: _____ For Credit Card offers, the following applies: [Pay [Charge] [Deduct] [Bill] [Frequency of Deductions/Bill Mode, referenced above] _____] from my credit/debit card (MC/VISA/Discover only) Acct # _____/_____/_____/_____ Exp. Date _____ [(MM/YY)] [(MM/YYYY)] [Print] Name of Card Holder _____ <p><input type="checkbox"/> Special Remarks: _____ [1X PAY] [\$1 DEVIATE] [TOKEN]</p> <p>Note: The Account Type choices above may be identified as a list, such as options or choices to select from with wording such as "Select One:". The choices could be presented as [Option A] [Option B] [Option C] or [Option 1] [Option 2] [Option 3], with or without checkboxes, and with instructions noted such as [Please check the type of account:] [Please check the type of account you prefer monthly deductions to occur from (check one only):].</p>

Form	Variable	Explanation
Continued for: A10f-036(J)-2012 A10f-037(J)-2012		<p><u>Coverage</u>: May be replaced with [coverage(s)]". May be either upper or lower case "c".</p> <p><u>Telephone</u>: May be replaced with the [phone]. May be either upper or lower case "t" in telephone or "p" in phone.</p> <p><u>Payment Default Language</u>: One of the following will be used:</p> <ol style="list-style-type: none"> 1. If you do not [select an account type,] [choose an option] [make an election] [If you leave this section blank] we will [deduct premiums from your] <u>Account Type</u>, referenced above], [bill you,] 2. If you do not choose an account, <u>or</u> provide a VOID [voided] check, deductions will occur from your <u>Account Type</u>, referenced above]. 3. If no account is selected, deductions will occur from my <u>Account Type</u>, referenced above]. 4. If you do not choose a type of account, or provide a VOID [voided] check, deductions will occur from your [financial institution type] [account type]. 5. If I do not designate an account, deductions will occur from my [account type]. <p>In addition, the following phrase or similar wording may or may not print: [I understand that selecting automatic payments allows me to get the lowest rate, as shown in this mailing.]</p> <p><u>Deduction Date Language</u>: One of the following sentences will be used: [Deductions will be determined by the policy effective date.] or [Deductions will be determined by the policy effective date unless another date is selected.]</p> <p><u>Payment Date Selection</u>:</p> <p>[Circle the day [date] of the month you prefer for account deductions: 1 5 10 15 20 25 Other Day ____] [The preferred day for my monthly deduction is ____.] [Preferred day for monthly deduction is ____.] [Please deduct my payment on the ____ of each month.] [Day of the month for deductions: ____.]</p> <p>Note: If appropriate, the disclosure language below (or very similar) will be included to describe when deductions will occur</p> <p>[(Note: Allow 2 business days from the above selected date for deductions to occur from your account. The <u>first</u> deduction may not be deducted on the day of the month you have selected. We will notify you in writing before the first deduction occurs.)]</p> <p>[(Note: Allow 2 business days from the above selected date for deductions to occur. The <u>first</u> deduction may not be deducted on the day of the month you selected. We will notify you in writing before the first deduction occurs.)]</p> <p>[(Note: The actual deduction will occur 2 business days after the day you select. The <u>first</u> deduction may not be deducted on the day of the month you have selected. We will notify you in writing before the first deduction occurs.)]</p> <p>[Note: I will allow 2 business days from the above date I selected for deductions to occur. The first deduction may not be deducted on the day of the month I selected. I will be notified in writing before the first deduction occurs.]</p> <p>[Note; Allow 2 business days from the date selected above for deductions to occur. The first deduction may not be made on the day of the month selected. You will be notified before the first deduction occurs.]</p>

Form	Variable	Explanation
Continued for: A10f-036(J)-2012 A10f-037(J)-2012	2. Direct Bill Payment Language [Direct Bill Language]	Voided Check Language: Will either be blank or will print one of the following: [Please enclose and write “VOID” on your check.] [Please enclose a voided check.] [Please write “VOID” on your check and tape it here.] [Please write “VOID” on your check and enclose.] Legal Disclosure Language: Will either be blank or will print one of the following: 1. *If you choose to have your monthly payments withdrawn electronically from your [Share] Savings account [for the purchase of this insurance offer], it will be considered one of six withdrawals allowed by law per statement cycle. 2. *If you choose to have your monthly payments withdrawn electronically from your [Share] Savings it will be considered one of six withdrawals allowed by law per statement cycle. Direct Bill Language: One of the following phrases may be included: [Please bill me.]. [Please bill me direct.] or [Please send me a bill.]
	Agreement	The last sentence of the first paragraph will appear only when the application is completed by an agent via telephone.
	Agent’s Signature Line	Will appear only when the application is completed by an agent via telephone, if required by state law.
	Agent Code	May or may not print. May be replaced with “Agent ID”.
	Card Holder’s Signature	Will appear only when application includes an offer for automatic premium deductions by credit card.
	Product ID	A product ID code will always print in the lower right hand corner of the form for administrative purposes.
	Directions at bottom of first page - CONTINUE ON BACK AND SIGN AND DATE	“CONTINUE ON BACK AND SIGN AND DATE” may be deleted, or may be revised for clarity. Directional arrows may also be added.
ADDITIONAL VARIABLES ONLY FOR: A10f-036(J)-2012	Height & Weight	The question may or may not appear.
	US Citizenship Question	The question may or may not appear.

CMFG Life Insurance Company - Memorandum of Variable Material – August 14, 2012
Forms: AMEND-2012

Variable	Explanation	
Company Logo	Allows for future changes to our logo. Logo may also be removed.	
Home Office Address & Telephone Number	Allows for future changes to the home office address and telephone number.	
Mailing Address	Represents individual insured's mailing address.	
Insured's name & Order/Policy Number	Individual insured's name will print. Either "Order" or "Policy" will print.	
Lead In Paragraph	Bracketed information will either print or not print. The appropriate "Product Description" will print. For example, "Term Life Insurance to Age 80" or "Whole Life Insurance coverage".	
Telephone Number	The telephone number in bracketed to allow for future change. Telephone Extension is bracketed & will be completed with the specific extension to be dialed.	
Body of Form. This is a dynamic form. Only those sections applicable to the individual will print.	Section Name	Variable Information
	ALIEN REGISTRATION CARD	Entire section will either print or not print.
	AVIATION QUESTIONNAIRE	Entire section will either print or not print.
	UNITED STATES CITIZENSHIP	Entire section will either print or not print. Bracketed information will either print or not print.
	CREDIT UNION INFORMATION	Entire section will either print or not print.
	HAZARDOUS SPORTS QUESTIONNAIRE	Entire section will either print or not print.
	HEIGHT	Entire section will either print or not print. The insured's name will print.
	MISSING INFORMATION	Entire section will either print or not print.
	OCCUPATION	Entire section will either print or not print. The insured's name will print.
	SOCIAL SECURITY NUMBER	Entire section will either print or not print. The insured's name will print.
	CHILDREN'S INSURANCE RIDER	Entire section will either print or not print. Bracketed information will either print or not print. The Amount of Coverage choices that print will depend on the Children's Insurance Rider offered.
	WEIGHT	Entire section will either print or not print. The insured's name will print.
	TELEPHONE NUMBER	Entire section will either print or not print. Bracketed information will either print or not print.
	ADDRESS CHANGE	Entire section will either print or not print.
	COVERAGE AMOUNT	Entire section will either print or not print.
	DATE OF BIRTH	Entire section will either print or not print.
	GENDER	Entire section will either print or not print.
	NAME VERIFICATION	Entire section will either print or not print.

	AUTOMATIC PAYMENT AUTHORIZATION Sections	<p>Entire section will either print or not print. The appropriate authorization section will print based on the original application that was completed. Subsections titled "Checking Name" or "Savings Name", if bracketed, indicates that only one or the other will print, as appropriate.</p> <p>Bracketed Variables:</p> <ul style="list-style-type: none"> • Checking Name: This will be the checking account name preferred by the financial institution (For example - "share draft/checking" or "checking".) • Savings Name: This will be the savings account name preferred by the financial institution (For example - "share/savings" or "savings".) • The word "Complete": May or may not print. • Account Name: This will be the savings or checking account name preferred by the financial institution (For example - "share/savings", "savings", "share draft/checking" or "checking".)
	SIGNATURE REQUIRED	Signature lines will appear if written consent is required for the type of change described in the amendment. If required the appropriate signature lines will print. The insured's name and/or owner's name will print, as applicable.
Order Number & Instructional Text	<p>The Order Number may or may not print at the bottom of each page. If printed, it is used for internal administrative purposes.</p> <p>The instructional text "Please look on the back of this form to see if more information is needed" will print only if the amendment consists of multiple pages. If there are multiple pages, the document print duplex and it will only print on every other page.</p>	
Document Identifier	A Document Identifier will print in lower right hand corner of the form for internal administrative use only. The document identifier could consist of any combination of words, letters, numbers or symbols, and could also include a bar code.	

CMFG Life Insurance Company - Memorandum of Variable Material – August 14, 2012
Forms: ENDORSE-2012

Variable	Explanation																				
Company Logo	Allows for future changes to our logo. Logo may also be removed.																				
Home Office Address & Telephone Number	Allows for future changes to the home office address and telephone number.																				
Name of Insured & Policy Number	Represents individual insured's data.																				
Effective Date	Will either print specific date or "SEE POLICY EFFECTIVE DATE".																				
Dictation Area	Any of the following types of variables may be printed in this area of the document.																				
	<table> <tr> <th>Type of Variable & Details</th><th>Variable Information</th></tr> <tr> <td>AMOUNT CHANGE</td><td> <p>The Policy face amount shown on the application was changed to [amount]¹.</p> <p align="center">OR</p> <p>Coverage on [insured's name] is [changed to/increased to/decreased to/issued for] [amount/units]¹.</p> <p>¹ <i>The amount or units represents the insured's data.</i></p> </td></tr> <tr> <td>REINSTATEMENT</td><td>Coverage on [insured's name] is reinstated under the Company's [rating] class.</td></tr> <tr> <td>GENDER</td><td>The gender of [insured's name /owner's name] is [male/female].</td></tr> <tr> <td>DATE OF BIRTH</td><td> <p>The date of birth of [insured's name/owner's name] is [month,day,year].</p> <p>[Coverage will expire on [month,day,year].]¹</p> <p>¹ <i>The entire sentence may or may not appear.</i></p> </td></tr> <tr> <td>NAME</td><td>The [insured/owner] of this policy is [name].</td></tr> <tr> <td>RATING</td><td>Coverage on [insured's name] is [changed to/issued under] the Company's [rating] class.</td></tr> <tr> <td>HEIGHT & WEIGHT</td><td> <p>One, or both of the following may print (without the bullets):</p> <ul style="list-style-type: none"> The weight of [insured name] is: _____. The height of [insured Name] is: _____. </td></tr> <tr> <td>RESTATEMENT OF APPLICATION QUESTIONS</td><td> <p><u>[RESTATED APPLICATION QUESTION]¹</u>.</p> <p>¹ <i>The Application Question will be restated exactly as it appeared on the filed application form.</i></p> <p><i>Lead in wording such as "Application Questions 3, 4, and 6(a) read:" may also print prior to restated application question.</i></p> </td></tr> <tr> <td>NO CASH</td><td> <p>It is understood and agreed that payment of the first full premium indicates acceptance of the Policy as issued and ratifies such changes and/or limitations as outlined in this endorsement.</p> <p><i>Used When Contract Is Sent Out C.O.D. or in situations where we have received automatic payment authorization, but have not drafted payment at the time the endorsement is sent.</i></p> </td></tr> </table>	Type of Variable & Details	Variable Information	AMOUNT CHANGE	<p>The Policy face amount shown on the application was changed to [amount]¹.</p> <p align="center">OR</p> <p>Coverage on [insured's name] is [changed to/increased to/decreased to/issued for] [amount/units]¹.</p> <p>¹ <i>The amount or units represents the insured's data.</i></p>	REINSTATEMENT	Coverage on [insured's name] is reinstated under the Company's [rating] class.	GENDER	The gender of [insured's name /owner's name] is [male/female].	DATE OF BIRTH	<p>The date of birth of [insured's name/owner's name] is [month,day,year].</p> <p>[Coverage will expire on [month,day,year].]¹</p> <p>¹ <i>The entire sentence may or may not appear.</i></p>	NAME	The [insured/owner] of this policy is [name].	RATING	Coverage on [insured's name] is [changed to/issued under] the Company's [rating] class.	HEIGHT & WEIGHT	<p>One, or both of the following may print (without the bullets):</p> <ul style="list-style-type: none"> The weight of [insured name] is: _____. The height of [insured Name] is: _____. 	RESTATEMENT OF APPLICATION QUESTIONS	<p><u>[RESTATED APPLICATION QUESTION]¹</u>.</p> <p>¹ <i>The Application Question will be restated exactly as it appeared on the filed application form.</i></p> <p><i>Lead in wording such as "Application Questions 3, 4, and 6(a) read:" may also print prior to restated application question.</i></p>	NO CASH	<p>It is understood and agreed that payment of the first full premium indicates acceptance of the Policy as issued and ratifies such changes and/or limitations as outlined in this endorsement.</p> <p><i>Used When Contract Is Sent Out C.O.D. or in situations where we have received automatic payment authorization, but have not drafted payment at the time the endorsement is sent.</i></p>
Type of Variable & Details	Variable Information																				
AMOUNT CHANGE	<p>The Policy face amount shown on the application was changed to [amount]¹.</p> <p align="center">OR</p> <p>Coverage on [insured's name] is [changed to/increased to/decreased to/issued for] [amount/units]¹.</p> <p>¹ <i>The amount or units represents the insured's data.</i></p>																				
REINSTATEMENT	Coverage on [insured's name] is reinstated under the Company's [rating] class.																				
GENDER	The gender of [insured's name /owner's name] is [male/female].																				
DATE OF BIRTH	<p>The date of birth of [insured's name/owner's name] is [month,day,year].</p> <p>[Coverage will expire on [month,day,year].]¹</p> <p>¹ <i>The entire sentence may or may not appear.</i></p>																				
NAME	The [insured/owner] of this policy is [name].																				
RATING	Coverage on [insured's name] is [changed to/issued under] the Company's [rating] class.																				
HEIGHT & WEIGHT	<p>One, or both of the following may print (without the bullets):</p> <ul style="list-style-type: none"> The weight of [insured name] is: _____. The height of [insured Name] is: _____. 																				
RESTATEMENT OF APPLICATION QUESTIONS	<p><u>[RESTATED APPLICATION QUESTION]¹</u>.</p> <p>¹ <i>The Application Question will be restated exactly as it appeared on the filed application form.</i></p> <p><i>Lead in wording such as "Application Questions 3, 4, and 6(a) read:" may also print prior to restated application question.</i></p>																				
NO CASH	<p>It is understood and agreed that payment of the first full premium indicates acceptance of the Policy as issued and ratifies such changes and/or limitations as outlined in this endorsement.</p> <p><i>Used When Contract Is Sent Out C.O.D. or in situations where we have received automatic payment authorization, but have not drafted payment at the time the endorsement is sent.</i></p>																				

	TOBACCO	<p>Coverage on [insured's name] is [changed to/issued under] the Company's [tobacco/non-tobacco/smoker/non-smoker] class.</p> <p style="text-align: center;">OR</p> <p>I have not used any form of tobacco [,including nicotine substitutes,] in the last twelve months.</p>
	RIDERS	<p>Any of the following may print (without the bullets):</p> <ul style="list-style-type: none"> • Coverage on [name] was added as [name of rider] for [face amount/units]. • The [name of rider] is issued with the policy. • The [name of rider] is not issued with the policy. • The [name of rider] is changed to \$[face amount]. • The [name of rider] excludes coverage on [insured's name]. • The [name of rider] has been removed. <p><i>Rider Names: Child Insurance Rider, Accidental Death Benefit Rider, etc.</i></p>
	PREMIUM	The [monthly/quarterly/semi-annual/annual/ACH] premium [is/was changed to] \$[amount].
	BENEFICIARY	<p>Any of the following may print (without the bullets):</p> <ul style="list-style-type: none"> • The [primary/contingent] beneficiary(ies) is/are [name or name and relationship]. • The [primary/contingent] beneficiary(ies) is/are [name and relationship], [fraction, percentage or specified dollar amount]. • The [primary/contingent] beneficiary(ies) is/are [name of trust] dated [date]; [name of trustee/s] or any successor trustee.
	COST OF LIVING DECLINE	The [date] Cost-Of-Living Benefit has been declined.
	ADDING CHILDREN	<p>The following child(ren) are added to your policy:</p> <p>[Child's Name]</p>
	CHANGE TO EXTENDED TERM INSURANCE	<p>Coverage has changed to Extended Term Insurance. The term insurance period expires on [month,day,year].</p> <p>The Extended Term Insurance amount is \$[amount].</p>
	CHANGE TO REDUCED PAID-UP INSURANCE	<p>Coverage has been changed to Reduced Paid-Up insurance. The Reduced Paid-Up Insurance amount is \$[amount].</p>
	RESTATEMENT OF AGREEMENT/AUTHORIZATION SECTION	<p><u>[RESTATED AGREEMENT/AUTHORIZATION SECTION]</u>¹.</p> <p>¹ The Agreement/ Authorization Section will be restated exactly as it appeared on the filed application form.</p> <p><i>Lead in wording such as "The application's Agreement-Authorization Section reads:" may also print prior to restated Agreement/Section wording.</i></p>

Statement of Health	<p>May be omitted in its entirety. The Statement of Health will print only if the Company needs to ask such questions to offer a policy acceptance agreement.</p> <p>In the event the owner is attesting to the health of the insured: (1) the variable <u>[my]</u> will be replaced with <u>[insured's name]</u>; and (2) the variable <u>[I have]</u> will be replaced with <u>[[insured's name] has]</u>.</p>
Signature Lines	Will appear if either written consent is required for the type of change described. If required the appropriate signature lines will print. The insured's name and/or owner's name will print, as applicable.
Officer's Signature & Title	If the Company's President should change, the new officer's signature will be reflected for new issues of the contract. In the event the title of an officer signing the policy form changes, any new title utilized will be the title of an officer of the company.
Document Identifier	A Document Identifier will print in lower right hand corner of the form for internal administrative use only. The document identifier could consist of any combination of words, letters, numbers or symbols, and could also include a bar code.



CMFG Life Insurance Company

FOR YOUR INFORMATION

Questions may be directed to:

**CMFG Life Insurance Company
2000 Heritage Way
Waverly, Iowa 50677
1-800-798-6600**

or

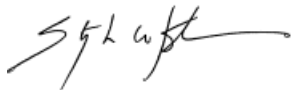
**Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
(501) 371-2640 or 1-800-852-5494**

Certificate of Compliance with Arkansas Rule and Regulation 19 & 49

Insurer: CMFG Life Insurance Company

Form Number(s): A10a-036-2012(AR)
A10a-037-2012(AR)
A10f-036(J)-2012
A10f-037(J)-2012
A10ad-ADB-2012
A10fd-ADB-2012
ENDORSE-2012
AMEND-2012

I hereby certify that to the best of my knowledge and belief, the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulations 19 and 49.



Signature of Company Officer

Stephen W. Koslow

Name

SVP, Chief Ethics & Compliance Officer

Title

August 2, 2012

Date

SERFF Tracking #:	CUNA-128479621	State Tracking #:		Company Tracking #:	A10A-037-2012(AR) & A10A-036-2012(AR), E...
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State: Arkansas
TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: CMFG 2012 UT80/UT80EZ
Project Name/Number: CMFG 2012 UT80/UT80EZ /

Filing Company: CMFG Life Insurance Company

Superceded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/23/2012	Supporting Document	Statement of Variability	08/17/2012	SoV A10a-036-2012 et al.pdf AMEND-2012 SoV.pdf (Superceded) ENDORSE-2012 SoV.pdf (Superceded)
07/23/2012	Form	Individual Life Application Amendment	08/17/2012	AMEND-2012.pdf (Superceded)

CMFG Life Insurance Company - Memorandum of Variable Material - June 29, 2012
Base Forms: A10a-036-2012, A10a-037-2012, A10f-036(J)-2012, A10f-037(J)-2012, A10ad-ADB-2012 & A10fd-ADB-2012

Form	Variable	Explanation
A10a-036-2012 A10a-037-2012	Company Logo	Allows for future changes to our logo. Logo may also be removed.
	Home Office Address & Telephone Number	Allows for future changes to the home office address and telephone number.
	John Doe Information on Policy Schedule	Bracketing shows variability for each individual insured. Brackets around the billing options allow the addition of billing options in the future if the company should choose to make them available. Brackets also allow for the removal of one or more billing option if the company should choose to do so.
	President and Secretary Signatures on Policy Face Page	Allows for future changes. If the Company's President or Secretary should change, the new officer's signature will be reflected for new issues of the policy.
	Premium Table	Bracketing shows variability for each individual insured. The premiums that are applicable to each individual insured are based on the individual's age, gender & tobacco status. The values shown are for filing purposes only, and may be revised to match the actuarial administrative system generated premiums, if any differences are discovered prior to the form being issued.
	Premium Class on Policy Schedule & Premium Table	Bracketing shows variability for each individual insured. <ul style="list-style-type: none"> Form A10a-036-2012 – Currently the only choice is "Standard". Form A10a-037-2012 - Currently the choices are: "Standard Tobacco", "Standard Non-Tobacco" "Rated Tobacco" & "Rated Non-Tobacco" In the event other premium classes are added, we will file a revised statement of variables prior to use.
Form	Variable	Explanation
A10ad-ADB-2012	Company Logo	Allows for future changes to our logo. Logo may also be removed.
	John Doe Information on Rider Schedule	Bracketing shows variability for each individual insured. Brackets around the billing options allow the addition of billing options in the future if the company should choose to make them available. Brackets also allow for the removal of one or more billing option if the company should choose to do so.
	President's Signature	Allows for future changes. If the Company's President should change, the new officer's signature will be reflected for new issues of the policy.
Form	Variable	Explanation
A10f-036(J)-2012 A10f-037(J)-2012 A10fd-ADB-2012 (See the last page for additional variables that apply to Form A10f-036(J)-2012 only.)	General Formatting	The application content will not be changed, except as provided in this document. However, the application may be reformatted, sections rearranged, and the ink colors, shading, highlighting and font types may be revised for direct mail marketing purposes.
	Home Office Address (& Telephone Number for form A10fd-ADB-2012)	Allows for future changes to the home office address and telephone number.
	Applicant & Spouse or Partner Name & Address Lines	This information is either written in by the applicant or a prepared mailing label is placed in this area.
	Email Address	Will either appear, or will be removed in its entirety.
	Phone Numbers	Any combination of Cell Phone, Primary Phone and/or Work Phone may be printed.
	State Variation Fraud Language	The field "State Variation Fraud Language" or "State Variations" will ONLY be used to add state language that may required by a particular state. It will not be used to alter the existing language approved and applicable to your state.
Form	Variable	Explanation
A10f-036(J)-2012 A10f-037(J)-2012	Marketing Name	"MEMBERS" is bracketed and may be removed or revised to be consistent with a new marketing name.
	Coverage Amount	Will either be a selection of coverage amounts (\$1,000 - \$25,000 for form A10f-036(J)-2012; and \$25,000 to \$250,000 for form A10f-037(J)-2012), or a blank line will appear to write in the coverage amount desired.
	Accidental Death Protection	The offer for Accidental Death Protection may or may not appear. The dollar amount will either be a specific dollar amount (\$25,000 to \$200,000) or a blank like will appear to write in the coverage amount desired.
	Internal Code	An internal code will print solely for administrative purposes.
	Instructional Text Preceding Questions	We may delete the bracketed information "If yes, please indicate √ the condition(s)" or replace it with similar types of instructional language such as: "If yes, please circle the condition(s)", "If yes, please check √ the condition(s)", or "If yes, please check √ below."

Form	Variable	Explanation
Continued for: A10f-036(J)-2012 A10f-037(J)-2012	Health Questions	<ul style="list-style-type: none"> • Check Boxes: The bracketed check boxes which precede the health conditions will appear only if we instruct the applicant to indicate or check the condition(s) for which they are answering “Yes”. The conditions that appear with checkboxes may also be reordered. None of the conditions will be deleted or revised in any other manner. • The questions may or may not be numbered. If numbered, Question #6 on form ICC12-A10f-037(J) may also be further divided into “a”, “b”, “c”, “d”, etc. • Question #7 on form ICC12-A10f-037(J) – Bracketed info may be deleted, moved to the “Details for Yes Questions area” or revised for clarity.
	Existing Coverage & Replacement Questions.	<ul style="list-style-type: none"> • Entire heading will not print if both questions are relocated to be part of the health questions section. If the questions are separated, the heading may be altered. For example: “Existing Coverage Question” or “Replacement Question” if the questions are separated. • The questions may or may not be numbered. • Existing insurance question will always print if the application is completed by an agent via telephone. The question may be deleted for direct mail applications.
	Details to Yes Questions Box	<ul style="list-style-type: none"> • “above” may be deleted or replaced with “on the reverse side”, or similar instructional location wording. • “Medical Professional” may be replaced with “Physician”.
	1. Automatic Billing Option Payment Language <i>The language below that is blue and bracketed corresponds to the Explanations to the RIGHT.</i> <u>[Section Title]</u> <u>[By signing]</u> <u>[Location of Signature]</u> I <u>[The Applicant]</u> <u>[Applicant Name Location]</u> authorize CMFG Life Insurance Company <u>[and the]</u> <u>[Financial Institution]</u> <u>[Location of Financial Institution Named]</u> to <u>[Action]</u> <u>[Frequency of Deductions]</u> <u>[Premiums From]</u> <u>[Pronoun]</u> <u>[Financial Institution Type]</u> , <u>[Account Selection Wording]</u> <u>[Account Type]</u> for the life <u>[Coverage]</u> applied for on this application. This authorization will remain in effect until revoked by me in writing or by <u>[Telephone]</u> . <u>[Payment Default Language]</u> <u>[Deduction Date Language]</u> <u>[Payment Date Selection]</u> <u>[Voided Check Language]</u> <u>[Legal Disclosure Language]</u>	<p>We may choose to bold, underline or capitalize certain words for emphasis and clarity in this billing language. Also, the billing language may be written either in the First Person Point of View (I) or the Second Person Point of View (you) for readability and clarity.</p> <p><u>Section Title:</u> Any combination of the following words – bracketed words may be removed entirely or used as other options:</p> <p>[LOWEST COST OPTION] [AUTOMATIC] [PAYMENT] [PAYMENTS] [AUTHORIZATION] [INFORMATION]: [(select one)]</p> <p>The phrase “<u>By signing</u>,” will print or will be deleted entirely.</p> <p><u>Location of Signature:</u> Either no location will print or language will be included explaining where the applicant should sign. For example, words/phrases such as [here] [below] [above] [to the right] or [to the left], [on reverse side] etc. may be used.</p> <p><u>The Applicant:</u> After the word “I” explanatory words such as [the applicant] or [the applicant shown] may be included. If they are deleted the copy reads “I authorize CMFG Life Insurance Company”</p> <p><u>Applicant Name Location:</u> Will either be blank, or language indicating location of where the applicant’s name is located will print after the word [shown]. These “location” words such as: [on the reverse side] [above] [below] [reverse side] etc. may be used.</p> <p><u>Financial Institution:</u> Will either be blank or may print [financial institution named] [credit union] [the actual credit union name] [bank] [bank name] or [Savings & Loan] [Savings & Loan name] or [Other Financial Institution] [Other Financial Institution named]. The Financial Institution Name may or may not be preceded with the words <u>[and the]</u>.</p> <p><u>Location of Financial Institution Named:</u> Will either be blank, or language indicating location of where the financial institution’s name is located will print such as: [on the reverse side] [above] [here/below] [here] [below] [reverse side] etc. may be used.</p> <p><u>Action:</u> Will either be blank, or one or a combination of the following words or phrases will print: [retain my account information] [and deduct] [and to deduct] [from my] [retain my account information and make automatic monthly premium deductions from my] [deduct premiums from the account I have designated below] [deduct] [deduct premiums]</p>

Form	Variable	Explanation
Continued for: A10f-036(J)-2012 A10f-037(J)-2012		<p>Frequency of Deductions/Bill Mode: Will be blank or one of the following bracketed words may be used: [monthly] [each month] [bi-monthly] [quarterly] [each quarter] [semi-annually] [semi-annual] [annually] [yearly] [once a year]</p> <p>Premiums From: Will either be blank or will be one of the following: [premiums each month from] [premiums from] [premiums] or [from]</p> <p>Pronoun: Will either be blank or the appropriate pronoun(s) or possessives will be used here, depending on need such as [my] [the] [I] [I have] or [I've]</p> <p>Financial Institution Type: Will either be blank or will print one of the following: [credit union]. [credit union name] [bank] [bank name] [Savings & Loan] [Savings & Loan name] or [Other] [Financial Institution]</p> <p>Account Selection Wording: Will either be blank or phrases will be used here such as; [the account I selected] [the account I've selected] or [the account I designated] or [the account I've designated]</p> <p>Account Type: Any combination of the following bracketed words/sections may or may not be included depending on the offer::</p> <ol style="list-style-type: none"> [credit union] [specific credit union name] [my financial institution] [share] [draft] [primary] [checking] [savings] [share draft (checking)] [share draft/checking account] [checking/savings] [OR] [or] [account] [acct.] [(provide account number)] [# _____] [Routing # _____] [Routing # _____] [(must be 9 digits)] [(please write it in)] [as provided here or over the phone] [the account I have designated below] [designated] [below] [indicated] [shown] [on the VOID check] [on the voided check] [Pay each [Frequency of Deductions/Bill Mode, referenced above] from my account listed below or] [(Option "A")] [(Option "B")] [(Option "C")] [from my credit card] [My checking account at the financial institution indicated on the VOID check [below] [above] [attached].] [My credit union] [account type]. [credit union] [primary] Share [Draft] [checking] [savings] [account] [Acct.] [# _____] [suffix #] [or suffix # _____] [(please write it in)] [as provided here or over the phone, designated below] [(if suffix is not indicated, suffix #90 for your Primary Share Draft account is assumed)] [Pay] [Deduct] [Bill] [each] [Frequency of Deductions/Bill Mode, referenced above] from my [Account Type, referenced above] account. Routing # _____ (must be 9 digits). Acct # _____ Day of the Month for Deductions: _____ For Credit Card offers, the following applies: [Pay [Charge] [Deduct] [Bill] [Frequency of Deductions/Bill Mode, referenced above] _____] from my credit/debit card (MC/VISA/Discover only) Acct # _____/_____/_____/_____ Exp. Date _____ [(MM/YY)] [(MM/YYYY)] [Print] Name of Card Holder _____ <p><input type="checkbox"/> Special Remarks: _____ [1X PAY] [\$1 DEVIATE] [TOKEN]</p> <p>Note: The Account Type choices above may be identified as a list, such as options or choices to select from with wording such as "Select One:". The choices could be presented as [Option A] [Option B] [Option C] or [Option 1] [Option 2] [Option 3], with or without checkboxes, and with instructions noted such as [Please check the type of account:] [Please check the type of account you prefer monthly deductions to occur from (check one only):].</p>

Form	Variable	Explanation
Continued for: A10f-036(J)-2012 A10f-037(J)-2012		<p><u>Coverage</u>: May be replaced with [coverage(s)]". May be either upper or lower case "c".</p> <p><u>Telephone</u>: May be replaced with the [phone]. May be either upper or lower case "t" in telephone or "p" in phone.</p> <p><u>Payment Default Language</u>: One of the following will be used:</p> <ol style="list-style-type: none"> 1. If you do not [select an account type,] [choose an option] [make an election] [If you leave this section blank] we will [deduct premiums from your] <u>Account Type</u>, referenced above], [bill you,] 2. If you do not choose an account, <u>or</u> provide a VOID [voided] check, deductions will occur from your <u>Account Type</u>, referenced above]. 3. If no account is selected, deductions will occur from my <u>Account Type</u>, referenced above]. 4. If you do not choose a type of account, or provide a VOID [voided] check, deductions will occur from your [financial institution type] [account type]. 5. If I do not designate an account, deductions will occur from my [account type]. <p>In addition, the following phrase or similar wording may or may not print: [I understand that selecting automatic payments allows me to get the lowest rate, as shown in this mailing.]</p> <p><u>Deduction Date Language</u>: One of the following sentences will be used: [Deductions will be determined by the policy effective date.] or [Deductions will be determined by the policy effective date unless another date is selected.]</p> <p><u>Payment Date Selection</u>:</p> <p>[Circle the day [date] of the month you prefer for account deductions: 1 5 10 15 20 25 Other Day ____] [The preferred day for my monthly deduction is ____.] [Preferred day for monthly deduction is ____.] [Please deduct my payment on the ____ of each month.] [Day of the month for deductions: ____.]</p> <p>Note: If appropriate, the disclosure language below (or very similar) will be included to describe when deductions will occur</p> <p>[(Note: Allow 2 business days from the above selected date for deductions to occur from your account. The <u>first</u> deduction may not be deducted on the day of the month you have selected. We will notify you in writing before the first deduction occurs.)]</p> <p>[(Note: Allow 2 business days from the above selected date for deductions to occur. The <u>first</u> deduction may not be deducted on the day of the month you selected. We will notify you in writing before the first deduction occurs.)]</p> <p>[(Note: The actual deduction will occur 2 business days after the day you select. The <u>first</u> deduction may not be deducted on the day of the month you have selected. We will notify you in writing before the first deduction occurs.)]</p> <p>[Note: I will allow 2 business days from the above date I selected for deductions to occur. The first deduction may not be deducted on the day of the month I selected. I will be notified in writing before the first deduction occurs.]</p> <p>[Note; Allow 2 business days from the date selected above for deductions to occur. The first deduction may not be made on the day of the month selected. You will be notified before the first deduction occurs.]</p>

Form	Variable	Explanation
Continued for: A10f-036(J)-2012 A10f-037(J)-2012	2. Direct Bill Payment Language [Direct Bill Language]	Voided Check Language: Will either be blank or will print one of the following: [Please enclose and write “VOID” on your check.] [Please enclose a voided check.] [Please write “VOID” on your check and tape it here.] [Please write “VOID” on your check and enclose.] Legal Disclosure Language: Will either be blank or will print one of the following: 1. *If you choose to have your monthly payments withdrawn electronically from your [Share] Savings account [for the purchase of this insurance offer], it will be considered one of six withdrawals allowed by law per statement cycle. 2. *If you choose to have your monthly payments withdrawn electronically from your [Share] Savings it will be considered one of six withdrawals allowed by law per statement cycle. Direct Bill Language: One of the following phrases may be included: [Please bill me.]. [Please bill me direct.] or [Please send me a bill.]
	Agreement	The last sentence of the first paragraph will appear only when the application is completed by an agent via telephone.
	Agent’s Signature Line	Will appear only when the application is completed by an agent via telephone, if required by state law.
	Agent Code	May or may not print. May be replaced with “Agent ID”.
	Card Holder’s Signature	Will appear only when application includes an offer for automatic premium deductions by credit card.
	Product ID	A product ID code will always print in the lower right hand corner of the form for administrative purposes.
	Directions at bottom of first page - CONTINUE ON BACK AND SIGN AND DATE	“CONTINUE ON BACK AND SIGN AND DATE” may be deleted, or may be revised for clarity. Directional arrows may also be added.
ADDITIONAL VARIABLES ONLY FOR: A10f-036(J)-2012	Height & Weight	The question may or may not appear.
	US Citizenship Question	The question may or may not appear.

CMFG Life Insurance Company - Memorandum of Variable Material – June 29, 2012
Forms: AMEND-2012

Variable	Explanation	
Company Logo	Allows for future changes to our logo. Logo may also be removed.	
Home Office Address & Telephone Number	Allows for future changes to the home office address and telephone number.	
Mailing Address	Represents individual insured's mailing address.	
Insured's name & Order/Policy Number	Individual insured's name will print. Either "Order" or "Policy" will print.	
Lead In Paragraph	Bracketed information will either print or not print. The appropriate "Product Description" will print. For example, "Term Life Insurance to Age 80" or "Whole Life Insurance coverage".	
Telephone Number	The telephone number in bracketed to allow for future change. Telephone Extension is bracketed & will be completed with the specific extension to be dialed.	
Body of Form. This is a dynamic form. Only those sections applicable to the individual will print.	Section Name	Variable Information
	ALIEN REGISTRATION CARD	Entire section will either print or not print.
	AVIATION QUESTIONNAIRE	Entire section will either print or not print.
	UNITED STATES CITIZENSHIP	Entire section will either print or not print. Bracketed information will either print or not print.
	CREDIT UNION INFORMATION	Entire section will either print or not print.
	HAZARDOUS SPORTS QUESTIONNAIRE	Entire section will either print or not print.
	HEIGHT	Entire section will either print or not print. The insured's name will print.
	MISSING INFORMATION	Entire section will either print or not print.
	OCCUPATION	Entire section will either print or not print. The insured's name will print.
	SOCIAL SECURITY NUMBER	Entire section will either print or not print. The insured's name will print.
	CHILDREN'S INSURANCE RIDER	Entire section will either print or not print. Bracketed information will either print or not print. The Amount of Coverage choices that print will depend on the Children's Insurance Rider offered.
	WEIGHT	Entire section will either print or not print. The insured's name will print.
	TELEPHONE NUMBER	Entire section will either print or not print. Bracketed information will either print or not print.
	ADDRESS CHANGE	Entire section will either print or not print.
	COVERAGE AMOUNT	Entire section will either print or not print.
	DATE OF BIRTH	Entire section will either print or not print.
	GENDER	Entire section will either print or not print.
	NAME VERIFICATION	Entire section will either print or not print.

	AUTOMATIC PAYMENT AUTHORIZATION Sections	<p>Entire section will either print or not print. The appropriate authorization section will print based on the original application that was completed.</p> <p>Bracketed Variables:</p> <ul style="list-style-type: none"> • Checking Name: This will be the checking account name preferred by the financial institution (For example - “share draft/checking” or “checking”). • Savings Name: This will be the savings account name preferred by the financial institution (For example - “share/savings” or “savings”). • Account Name: This will be the savings or checking account name preferred by the financial institution (For example - “share/savings”, “savings”, “share draft/checking” or “checking”). • Bank Name: If the Bank Name is known, it will be printed, otherwise a blank line will appear. • Bank Address: If the Bank Address is known, it will be printed, otherwise a blank line will appear. • Account Number: If the account number is known, it will be printed, otherwise a blank line will appear. • The word “Complete”: May or may not print
	SIGNATURE REQUIRED	Signature lines will appear if written consent is required for the type of change described in the amendment. If required the appropriate signature lines will print. The insured’s name and/or owner’s name will print, as applicable.
Order Number & Instructional Text	<p>The Order Number may or may not print at the bottom of each page. If printed, it is used for internal administrative purposes.</p> <p>The instructional text “Please look on the back of this form to see if more information is needed” will print only if the amendment consists of multiple pages. If there are multiple pages, the document print duplex and it will only print on every other page.</p>	
Document Identifier	A Document Identifier will print in lower right hand corner of the form for internal administrative use only. The document identifier could consist of any combination of words, letters, numbers or symbols, and could also include a bar code.	

CMFG Life Insurance Company - Memorandum of Variable Material – June 29, 2012
Forms: ENDORSE-2012

Variable	Explanation	
Company Logo	Allows for future changes to our logo. Logo may also be removed.	
Home Office Address & Telephone Number	Allows for future changes to the home office address and telephone number.	
Name of Insured & Policy Number	Represents individual insured's data.	
Effective Date	Will either print specific date or "SEE POLICY EFFECTIVE DATE".	
Dictation Area	Any of the following types of variables may be printed in this area of the document.	
	Type of Variable & Details	Variable Information
	AMOUNT CHANGE	The Policy face amount shown on the application was changed to [amount] ¹ . OR Coverage on [insured's name] is [changed to/increased to/decreased to/issued for] [amount/units] ¹ . ¹ <i>The amount or units represents the insured's data.</i>
	REINSTATEMENT	Coverage on [insured's name] is reinstated under the Company's [rating] class.
	GENDER	The gender of [insured's name /owner's name] is [male/female].
	DATE OF BIRTH	The date of birth of [insured's name/owner's name] is [month,day,year].
	NAME	The [insured/owner] of this policy is [name].
	RATING	Coverage on [insured's name] is issued under the Company's [rating] class.
	HEIGHT & WEIGHT	One, or both of the following may print: <ul style="list-style-type: none"> The weight of [insured name] is: _____. The height of [insured Name] is: _____.
	RESTATEMENT OF APPLICATION QUESTIONS	<u>[RESTATED APPLICATION QUESTION]¹</u> . ¹ <i>The Application Question will be restated exactly as it appeared on the filed application form.</i> <i>Lead in wording such as "Application Questions 3, 4, and 6(a) read:" may also print prior to restated application question.</i>
	NO CASH	It is understood and agreed that payment of the first full premium indicates acceptance of the Policy as issued and ratifies such changes and/or limitations as outlined in this endorsement. <i>Used When Contract Is Sent Out C.O.D. or in situations where we have received automatic payment authorization, but have not drafted payment at the time the endorsement is sent.</i>

	TOBACCO	Coverage on [insured's name] is issued under the Company's [tobacco/non-tobacco] class. OR I have not used any form of tobacco [,including nicotine substitutes,] in the last twelve months.
	RIDERS	Any of the following may print: <ul style="list-style-type: none"> • Coverage on [name] was added as [name of rider] for [face amount/units]. • The [name of rider] is issued with the policy. • The [name of rider] is not issued with the policy. • The [name of rider] is changed to \${face amount}. • The [name of rider] excludes coverage on [insured's name]. <i>Rider Names: Child Insurance Rider, Accidental Death Benefit Rider, etc.</i>
	PREMIUM	The [monthly/quarterly/semi-annual/annual/ACH] premium [is/was changed to] \${amount}.
	BENEFICIARY	Any of the following may print: <ul style="list-style-type: none"> • The [primary/contingent] beneficiary(ies) is/are [name or name and relationship]. • The [primary/contingent] beneficiary(ies) is/are [name and relationship], [fraction, percentage or specified dollar amount]. • The [primary/contingent] beneficiary(ies) is/are [name of trust] dated [date]; [name of trustee/s] or any successor trustee.
	RESTATEMENT OF AGREEMENT/AUTHORIZATION SECTION	<u>[RESTATED AGREEMENT/AUTHORIZATION SECTION]</u> ¹ . ¹ <i>The Agreement/ Authorization Section will be restated exactly as it appeared on the filed application form.</i> <i>Lead in wording such as "The application's Agreement-Authorization Section reads:" may also print prior to restated Agreement/Section wording.</i>
Statement of Health	May be omitted in its entirety. The Statement of Health will print only if the Company needs to ask such questions to offer a policy acceptance agreement. In the event the owner is attesting to the health of the insured: (1) the variable [my] will be replaced with [insured's name]; and (2) the variable [I have] will be replaced with [[insured's name] has].	
Signature Lines	Will appear if either written consent is required for the type of change described. If required the appropriate signature lines will print. The insured's name and/or owner's name will print, as applicable.	
Officer's Signature & Title	If the Company's President should change, the new officer's signature will be reflected for new issues of the contract. In the event the title of an officer signing the policy form changes, any new title utilized will be the title of an officer of the company.	
Document Identifier	A Document Identifier will print in lower right hand corner of the form for internal administrative use only. The document identifier could consist of any combination of words, letters, numbers or symbols, and could also include a bar code.	



CMFG Life Insurance Company

2000 Heritage Way
Waverly, IA 50677-0061
Phone: 800.779.5433

[John Doe]
[1234 Main Street]
[Anywhere, State 98765]

Amendment to Application

Insured's name: [John Doe]

[Order/Policy] Number: [123456789]

We have received your request [to convert your term policy to [Product Description]] [for [Product Description]]. This form asks for information that is either unclear or incomplete from the Application. Please review the sections that follow and provide the details requested. It is important to verify that all information is accurate. **[Please complete, sign and date this document. Also, complete, sign and date the enclosed Endorsement. Return both forms to us in the envelope provided by [Required Due Date]], [Please return this document, signed and dated, in the envelope provided by [Required DueDate],] [so we can complete your request. If we do not hear from you by this date, we will need to close your file.] [so we can complete our records.]**

Thank you for your time and prompt attention to this matter. If you have questions, please call [1-800-779-5433], [4831234].

ALIEN REGISTRATION CARD

After reviewing the application, we note that you are not currently a U.S. citizen. Therefore, it will be necessary for us to receive a photocopy of your Alien Registration card.

PLEASE RETURN THE PHOTOCOPY OF YOUR ALIEN REGISTRATION CARD WITH THIS FORM.

AVIATION QUESTIONNAIRE

We need to clarify your participation in aviation activities. Please complete the enclosed questionnaire and return it to our office in the envelope provided.

UNITED STATES CITIZENSHIP

[State/Country where you were born? _____]

Are you a United States citizen? Yes ____ No ____

If you are **not** a United States citizen, it is necessary for us to receive a photocopy of your Alien Registration Card.

PLEASE RETURN THE PHOTOCOPY OF YOUR ALIEN REGISTRATION CARD WITH THIS FORM.

[Order Number] [Please look on the back of this form to see if more information is needed.]

CREDIT UNION INFORMATION

Credit Union Name: _____

Address (Street, City, State, Zip Code): _____

HAZARDOUS SPORTS QUESTIONNAIRE

We need to clarify your participation in hazardous sports. Please complete the enclosed questionnaire and return it to our office in the envelope provided.

HEIGHT

The height of [Insured's Name] is: _____

MISSING INFORMATION

There was information missing from the application. Please refer to the enclosed endorsement to complete this information.

OCCUPATION

The occupation of [Insured's Name] is: _____

SOCIAL SECURITY NUMBER

[Insured's Name]

____ - ____ - _____

CHILDREN'S INSURANCE RIDER

Please provide the missing details for the individuals covered under this rider below.

[Child's Name: First _____ Last _____]

[Date of Birth: ______]

[Gender: __male __female]

[Amount of Coverage (please circle the amount you want): [\$5,000 \$10,000]]

WEIGHT

The weight of [Insured's Name] is: _____

[Order Number] [Please look on the back of this form to see if more information is needed.]

TELEPHONE NUMBER

Please provide a telephone number where we can contact you and the time that is most convenient.

Home Telephone (including area code): _____ - _____ - _____

Best Time to Call: _____

[Work Telephone (including area code): _____ - _____ - _____]

[Best Time to Call: _____]

[Cell Telephone (including area code): _____ - _____ - _____]

[Best Time to Call: _____]

ADDRESS CHANGE

If your name, address, or phone number has changed, please provide the correct information below:

Name: _____

Mailing Address: _____

City, State, Zip: _____

Phone Number (Including area code): _____ - _____ - _____

COVERAGE AMOUNT

The amount of insurance was not marked on your application. (See the enclosed copy, which is included for your information. Do not return the enclosed copy of the application.)

Please indicate the coverage amount you wish to apply for: \$_____

DATE OF BIRTH

Month ____ Day ____ Year ____

GENDER

Male ____ Female ____

NAME VERIFICATION

The name provided is incomplete or unclear. Please print this information below.

Insured

First Name: _____ Middle Name: _____ Last Name: _____

[Order Number] [Please look on the back of this form to see if more information is needed.]

AUTOMATIC PAYMENT AUTHORIZATION

Information on the financial institution you want us to automatically deduct your premiums from is needed. Please choose from either [Checking Name] or [Savings Name].

[Checking Name]

Account Number: _____

Please include a voided check - *Note: This is needed to establish this payment plan*

[Savings Name]

Complete Financial Institution Name: _____

Financial Institution Phone Number (including area code): _____

Financial Institution Address: _____

(street, city, state, zip) _____

[Savings Name] Account Number: _____

Please indicate the day (1-31) of the month you want the premium drawn from your account: _____

Check how often you want premiums drawn from your account:

____ Monthly ____ Quarterly ____ Semi-annually ____ Annually

FINANCIAL ACCOUNT OWNER SIGNATURE

I authorize CMFG Life Insurance Company and the financial institution named here to retain my account information and initiate deductions or credits to my account either by electronic funds transfer or paper draft. This authorization will remain in effect until revoked by me in writing. Deductions will be determined by the policy due date unless another date is selected.

Accountholder's Signature (if different than insured): _____

Date Signed: _____

[Order Number] [Please look on the back of this form to see if more information is needed.]

AUTOMATIC PAYMENT AUTHORIZATION

You requested to have payments taken from your [Account Name] account. Your financial institution only allows automatic payments from your [Account Name] account. Please provide the details requested below so payments can be deducted from your [Account Name] account.

[Checking Name]

Account Number: _____

Please include a voided check - *Note: This is needed to establish this payment plan*

[Savings Name]

Complete Financial Institution Name: _____

Financial Institution Phone Number (including area code): _____

Financial Institution Address: _____

(street, city, state, zip) _____

[Savings Name] Account Number: _____]

Please indicate the day (1-31) of the month you want the premium drawn from your account: _____

Check how often you want premiums drawn from your account:

____ Monthly ____ Quarterly ____ Semi-annually ____ Annually

FINANCIAL ACCOUNT OWNER SIGNATURE

I authorize CMFG Life Insurance Company and the financial institution named here to retain my account information and initiate deductions or credits to my account either by electronic funds transfer or paper draft. This authorization will remain in effect until revoked by me in writing. Deductions will be determined by the policy due date unless another date is selected.

Accountholder's Signature (if different than insured): _____

Date Signed: _____

[Order Number] [Please look on the back of this form to see if more information is needed.]

AUTOMATIC PAYMENT AUTHORIZATION

Information on the financial institution you want us to automatically deduct your premiums from is needed.

[Savings Name]

Complete Financial Institution Name: [Bank Name or blank line]

Financial Institution Phone Number (including area code): _____

Financial Institution Address: [Bank Address or blank line]

(street, city, state, zip)

[Savings Name] Account Number: [Account Number, or Blank Line]

[Checking Name]

Complete Financial Institution Name: [Bank Name]

Account Number: [Account Number or Blank Line]

Please include a voided check - *Note: This is needed to establish this payment plan.*

Please indicate the day (1-31) of the month you want the premium drawn from your account: _____

Check how often you want premiums drawn from your account:

____ Monthly ____ Quarterly ____ Semi-annually ____ Annually

FINANCIAL ACCOUNT OWNER SIGNATURE

I authorize CMFG Life Insurance Company and the financial institution named here to retain my account information and initiate deductions or credits to my account either by electronic funds transfer or paper draft. This authorization will remain in effect until revoked by me in writing. Deductions will be determined by the policy due date unless another date is selected.

Accountholder's Signature (if different than insured): _____

Date Signed: _____

[Order Number] [Please look on the back of this form to see if more information is needed.]

AUTOMATIC PAYMENT AUTHORIZATION

Thank you for providing your account information. This authorization needs to be signed before payments can be taken from your account.

[Checking Name]/[Savings Name]

[Complete] Financial Institution Name: [Bank Name or blank line]

[Savings Name] Account Number: [Account Number or blank line]

Please indicate the day (1-31) of the month you want the premium drawn from your account: _____

Check how often you want premiums drawn from your account:

____ Monthly ____ Quarterly ____ Semi-annually ____ Annually

FINANCIAL ACCOUNT OWNER SIGNATURE

I authorize CMFG Life Insurance Company and the financial institution named here to retain my account information and initiate deductions or credits to my account either by electronic funds transfer or paper draft. This authorization will remain in effect until revoked by me in writing. Deductions will be determined by the policy due date unless another date is selected.

Accountholder's Signature (if different than insured): _____

Date Signed: _____

SIGNATURE REQUIRED

I declare that all statements and answers made above are full, true and complete to the best of my knowledge and belief. I agree that this information will be a part of the original application and any policy issued on the basis of the application.

[_____] _____
[DATE SIGNATURE OF [Insured Name]]

[_____] _____
[DATE SIGNATURE OF [Owner Name]]

[_____] _____
[DATE SIGNATURE OF PARENT OR GUARDIAN OF [Insured Name]]

[Order Number] [Please look on the back of this form to see if more information is needed.]